IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SCAN HEALTH PLAN,

Plaintiff,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

Case No. 1:23-cv-3910-CJN

JOINT APPENDIX

VOLUME I

Tabs 1 – 21

Rulemaking Record ("R.R.")

Tab	Document Description	R.R. Page Range
1	Comment of SCAN Foundation to Proposed Tukey Outlier Deletion Rule, 85 Fed. Reg. 9,002 (Feb. 18, 2020)	264 – 270
2	Comment of UCare to Proposed Tukey Outlier Deletion Rule, 85 Fed. Reg. 9,002 (Feb. 18, 2020)	271 – 280
3	Comment of SCAN Health Plan to Proposed Tukey Outlier Deletion Rule, 85 Fed. Reg. 9,002 (Feb. 18, 2020)	377 – 385
4	Comment of Association for Community Affiliated Plans to Proposed Tukey Outlier Deletion Rule, 85 Fed. Reg. 9,002 (Feb. 18, 2020)	386 – 390
5	Comment of Blue Cross Blue Shield Association to Proposed Tukey Outlier Deletion Rule, 85 Fed. Reg. 9,002 (Feb. 18, 2020)	391 – 440

6	Comment of America's Health Insurance Plans (AHIP) to Proposed Tukey Outlier Deletion Rule, 85 Fed. Reg. 9,002 (Feb. 18, 2020)	506 – 576
7	Comment of Elevance (f/k/a Anthem, Inc.) to Proposed Tukey Outlier Deletion Rule, 85 Fed. Reg. 9,002 (Feb. 18, 2020)	577 – 627
8	Comment of Humana, Inc. to Proposed Tukey Outlier Deletion Rule, 85 Fed. Reg. 9,002 (Feb. 18, 2020)	637 – 733
9	Comment of Gateway Health to Proposed Tukey Outlier Deletion Rule, 85 Fed. Reg. 9,002 (Feb. 18, 2020)	734 – 737
10	Comment of Alliance of Community Health Plans to Proposed Tukey Outlier Deletion Rule, 85 Fed. Reg. 9,002 (Feb. 18, 2020)	825 – 837
11	Comment of SCAN Health Plan to Proposed Technical Amendment, 87 Fed. Reg. 79,452 (Dec. 27, 2022)	1742 – 1750
12	Comment of AHIP to Proposed Technical Amendment, 87 Fed. Reg. 79,452 (Dec. 27, 2022)	1769 – 1827
13	Comment of UnitedHealth Group to Proposed Technical Amendment, 87 Fed. Reg. 79,452 (Dec. 27, 2022)	1894 – 1940
14	Comment of CVS Health to Proposed Technical Amendment, 87 Fed. Reg. 79,452 (Dec. 27, 2022)	1974 – 2028
15	Comment of Alignment Health to Proposed Technical Amendment, 87 Fed. Reg. 79,452 (Dec. 27, 2022)	2147 – 2162
16	Comment of the Pharmaceutical Care Management Association to Proposed Technical Amendment, 87 Fed. Reg. 79,452 (Dec. 27, 2022)	2169 – 2231
17	Comment of Elevance Health to Proposed Technical Amendment, 87 Fed. Reg. 79,452 (Dec. 27, 2022)	2232 – 2308
18	Comment of Village MD to Proposed Technical Amendment, 87 Fed. Reg. 79,452 (Dec. 27, 2022)	2309 – 2312

19	Comment of Blue Shield of California to Proposed Technical Amendment, 87 Fed. Reg. 79,452 (Dec. 27, 2022)	2313 – 2326
20	Comment of Cigna Group to Proposed Technical Amendment, 87 Fed. Reg. 79,452 (Dec. 27, 2022)	2449 – 2469
21	CMS December 19, 2022 Simulations and Memorandum	2705 – 2715

TAB 1

PUBLIC SUBMISSION

As of: January 25, 2024
Received: March 16, 2020
Status: Posted
Posted: March 18, 2020
Tracking No. 1k4-9fl4-ehb6
Comments Due: April 06, 2020
Submission Type: API

Docket: CMS-2020-0010
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2021 (CMS-4190-P)

Comment On: CMS-2020-0010-0002
Medicare and Medicaid Programs: Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Document: CMS-2020-0010-0032
Comment on CMS-2020-0010-0002

Submitter Information

Name: Megan Burke
Address:
Long Beach, CA, 90806
Email: mburke@thescanfoundation.org
Organization: The SCAN Foundation

General Comment

See attached file(s)

Attachments

The SCAN Foundation_2021-2022 MA NPRM_Comments_Final

March 16, 2020

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4190–P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: *Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly* (CMS–4190–P)

To whom it may concern:

The SCAN Foundation (Foundation) welcomes the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) request for comment on the proposed rule for the *Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly* (CMS–4190–P). The Foundation is an independent public charity devoted to transforming care for older adults in ways that preserve dignity and encourage independence. We envision a future where high-quality, affordable health care and supports for daily living are delivered on each person's own terms, according to that individual's needs, values, and preferences.

The proposed rules demonstrate CMS' effort to improve the current infrastructure to support person-centered care and integrated care for people with complex care needs and those dually eligible for Medicare and Medicaid. We are pleased to see CMS' proposal to codify Special Supplemental Benefits for the Chronically Ill (SSBCI) standards, improve care coordination in special needs plans, and address Dual Eligible Special Needs Plan (D-SNP) look-alike plans. The following comments highlight CMS action the Foundation supports, opportunities to strengthen proposals, and information that will be helpful as CMS continues work to implement the *CHRONIC Care Act*.

Special Supplemental Benefits for the Chronically Ill (SSBCI) (§ 422.102)

Implementation of the SSBCI represents a turning point in Medicare policy with Medicare Advantage plans able to provide non-health related benefits. Such non-medical supplemental benefits play a key role in meeting individuals needs and managing health care. The Foundation

supports the CMS proposal to codify the 2019 guidance on the SSBCI and the additional flexibilities for identifying eligible chronic conditions. This action signifies CMS' continued commitment and forward trend to address non-medical needs and social determinants of health for people with complex care needs.

In 2019, a working group of national experts developed *Guiding Principles for New Flexibility Under Special Supplemental Benefits for the Chronically Ill* to guide implementation. These principles illustrate a common vision for how Medicare can create the flexibility necessary to meet individual needs balanced, with appropriate guardrails to protect beneficiaries, providers, Medicare Advantage plans, and the integrity of the Medicare program overall.

Along with the next steps listed in the Guiding Principles, we offer the following recommendations to strengthen SSBCI for future implementation.

1) Define intensive care coordination. The definition of chronically ill enrollee has three components that an individual must meet to be eligible for SSBCI. The third component that that an individual requires intensive care coordination has not been clearly defined in previous guidance. The Essential Attributes of high-quality care, a resource developed by a panel of national experts, provides a person-centered framework for care coordination. The Playbook also offers resources on operationalizing intensive models of care coordination. We recommend CMS draw from these resources to develop guidance to define intensive care coordination that goes beyond the standard coordination of services already required of MA plans.

2) Require functional assessment questions in MA Health Risk Assessments (HRA) to target SSBCI: High-quality systems of care assess an individual's functional and social determinants of health (SDOH) needs to best align services with an individual's needs and goals. The first touch point for this information is the mandatory HRA. Learning from a 2014 Avalere Health report, more can be done through the HRA to elicit an individual's goals and values, and to use both medical and non-medical information in care planning and coordination. For example, California's Department of Health Care Services recently required all Medicaid managed care plans to include 10 questions in their HRAs that identify functional and social support needs. A recent Center for Health Care Strategies report highlights additional tools to assess for SDOH, and current efforts by complex care programs to begin tracking outcomes. CMS has provided MA plans flexibility in creating processes for identifying eligible enrollees for SSBCI based on need. We recommend that CMS require all MA plans to include functional assessment questions in their HRAs and implement a process to coordinate these responses with other important health-related information for care planning and coordination of SSBCI.

3) Publicize SSBCI data to support development and implementation. As SSBCI is a new benefit structure, there is much to be learned to ensure individuals' needs are being met effectively and efficiently. The first step is accessing data for analysis of benefit offerings. There is strong stakeholder interest in SSBCI data analysis to better

understand what plans are offering, to whom, and where. We recommend CMS make SSBCI data and analyses available to the public in a timely manner to support benefit development, collaboration, learning, and innovation.

4) Implement proposal to include SSBCI in the medical loss ratio (MLR) numerator. Current policy only allows MA plans to include supplemental benefits in the MLR that have direct claims to Medicare providers or qualify under Quality Improvement Activities. The CMS proposal to include all primarily health-related supplemental benefits and SSBCI in the MLR numerator aligns with the Guiding Principles report that calls for policies to support provision of SSBCI – specifically by eliminating the need for plans to assess individual benefits for qualification under Quality Improvement Activities. We recommend that CMS move forward with this proposed change and include it in the final rule.

Improvements to Care Management Requirements for Special Needs Plans (SNPs) (§ 422.101)

Incorporate elements of person-centered care in Model of Care (MOC). We support CMS' proposal to apply the more comprehensive Chronic Special Needs Plan (C-SNP) MOC requirements found in section 1859(f)(5)(B) of the *Social Security Act*, addressing care management requirements and MOC goal review, to all special needs plans as these requirements build the basis for person-centered care. However, CMS could apply more rigorous person-centered care requirements to strengthen the MOC and better meet people's needs. High quality systems of care coordinate both medical and non-medical services in accordance with a person's needs and preferences. The Essential Attributes for developing high quality systems of care operationalizes elements of person-centered assessments, individualized care plans (ICP), and care coordination. Additionally, section 2.8 of the three-way contract for California's financial alignment demonstration (Cal MediConnect) provides example language for requiring person-centered assessment, ICPs, and care coordination. We recommend CMS draw on the Essential Attributes and Cal MediConnect three-way contract to build out person-centered requirements for the SNP MOC.

Contracting Standards for D-SNP Look-Alike Plans (§ 422.514)

To ensure dual eligible individuals have access to high-quality integrated care, it is important to have a clear distinction between truly-integrated models of care and regular MA plans. The growing number of D-SNP look-alike plans has created challenges for implementing integrated care in California. As such, we support CMS' proposal to not contract with look-alikes in states with D-SNPs or other health plan products that integrate care for this population. Additionally, we recommend CMS work with states to monitor enrollment of full-benefit dual eligible individuals in D-SNP look-alike plans, and use potential pathways to resolve this issue.

Pathways for resolution include the following:

1) Designate MA plans with dual eligible individuals representing over 60 percent of enrollment as look-alike plans. The proposed rule would subject MA plans predominately serving dual eligible individuals (over 80% of enrollment) to D-SNP rules. In 2019, MedPAC reported that look-alike enrollment of dual eligible individuals is more than 95 percent compared to 97 percent for D-SNPs. MedPAC also reported that in most MA markets the proportion of dual eligible individuals as a percentage of the enrollment is 10-25 percent and generally does not exceed 50 percent. The proposed 80 percent threshold seems high being that dual eligible individuals reportedly make up less than 50 percent of the overall MA market. We recommend CMS lower the look-alike dual eligible enrollment threshold to 50 percent.

2) Share data on MA plans with dual eligible enrollment above the look-alike threshold. States do not have access to specific MA data, and often find it difficult to identify D-SNP look-alike plans in their markets. In states implementing integrated care models, access to D-SNP look-alike data would be useful to identify potential look-alike plans and develop appropriate oversight and regulatory solutions. We recommend CMS inform and share data with states on MA plans that have at least 20 percent dual eligible enrollees.

3) Ensure consumer protections for individuals transitioned out of look-alikes. The proposed look-alike transition plan would allow a look-alike plan to transition individuals to a D-SNP or non-SNP MA plan within the same parent organization as long as the receiving plan is in the same service area and has a combined Part C and D premium of $0. There were many lessons learned during the implementation of Cal MediConnect in California that elevated the importance of consumer protections such as continuity of care and network parity. During the transition to Cal MediConnect, the state implemented continuity of care standards and provided guidance allowing the receiving Cal MediConnect plan to use the HRA completed by a D-SNP. To minimize disruptions in care, CMS should also consider consumer protections similar to those in California's CalAIM D-SNP proposal transition plan. We recommend CMS develop requirements for transferring an enrollee's HRA and ICP, as well as requirements for continuity of care, network parity, and not allowing receiving plans to impose additional cost-sharing requirements.

4) Develop marketing guidelines and tools that promote integrated care. Many individuals do not understand their choices for integrated care, the benefits of integrated care, and how to access integrated care options. The marketing of look-alike plans to dual eligible individuals causes confusion for those who think they are enrolling in a health plan that will coordinate their Medicare and Medi-Cal, and can lead to disruptions and gaps in care. We support CMS' proposal to codify sub regulatory guidance that prohibits MA organizations from marketing non-D-SNP plans as D-SNPs (i.e., targeting duals, implying the plans are designed for duals, claiming relationship with state Medicaid agency). In

addition to prohibiting false-marketing, it is critical that individuals with Medicare and Medicaid are fully informed about the differences between truly-integrated care and other options. As such, we recommend the following actions.

- Require that plan agents and brokers for a MA plan, that is not a D-SNP or other integrated care model, identify dual eligible individuals and explain that the plan is not an integrated product and does not have a contract with the state to coordinate Medicaid benefits. Further, dual eligible individuals should be provided a list and contact information of integrated products offered in the plan service area. This should be a standard communication prepared by the plan and reviewed by CMS.

- Require that, upon receipt of the application of a dual eligible individual, any non-integrated plan must initiate an outbound verification call to confirm that the dual eligible beneficiary understands the limits of the plan. The plan representatives should be trained on how any supplemental benefits offered by the plan overlap or interact with the Medicaid benefits in that state and offer assistance to the beneficiary in understanding the basic relationship. Any dual eligible individuals who enroll in a non-integrated plan should at a minimum understand how the plan does and does not coordinate Medicaid benefits.

- Invest in an education campaign for State Health Insurance Assistance Program (SHIP) counselors to provide clear guidance on how best to help Medicare/Medi-Cal enrollees understand integrated care choices (e.g., enrollment implications, care coordination).

- Adopt a public-facing web platform for dual eligible individual, similar to MyCareMyChoice.org, as part of Medicare Plan Finder or other platform to assist consumers and trusted advisors with understanding integrated care choices in their local community.

5) Coordinate look-alike transition timeline with state integrated care transition timelines. The proposed prohibition on D-SNP look a-likes (2022) with 2020 look a-likes transitions for 2021 enrollments may create confusion and barriers for beneficiaries and health plans if not aligned with integration efforts in the states. For example, California has proposed an integrated care transition plan (Cal MediConnect to D-SNP model) that includes transitioning to an aligned Medi-Cal/D-SNP model. The current timeline does not coordinate with CMS' proposed look-alike transition timeline. Multiple changes to the service system that are not carefully coordinated between the state and CMS can negatively impact integrated care implementation, enrollment, health plan involvement, and the individual's care experience. We recommend CMS coordinate the look-alike transition timeline with states whose integrated care systems would be greatly impacted to ensure the state and health plans have the capacity to address the multiple transitions and maximize outcomes.

Overall, we are pleased by the proposals set forth from CMS, which recognize the important role of non-medical benefits and person-centered integrated care in providing care to Medicare beneficiaries with complex care needs. Thank you for the opportunity to review and comment on the proposed rule. Please feel free to contact us for any additional information.

Sincerely,

Bruce A. Chernof, M.D.
President and CEO

TAB 2

PUBLIC SUBMISSION

As of: January 25, 2024
Received: April 03, 2020
Status: Posted
Posted: April 06, 2020
Tracking No. 1k4-9fx2-18go
Comments Due: April 06, 2020
Submission Type: Web

Docket: CMS-2020-0010
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2021 (CMS-4190-P)

Comment On: CMS-2020-0010-0002
Medicare and Medicaid Programs: Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Document: CMS-2020-0010-0209
Comment on CMS-2020-0010-0002

Submitter Information

Name: Anonymous Anonymous

General Comment

See attached file(s)

Attachments

20200402 UCare Comments (CMS-4190-P)

April 2, 2020

Delivered to: www.regulations.gov

Good Afternoon,

Thank you for the opportunity to submit comments on the *Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4190-P)* proposed rule. UCare provides the following comments for consideration.

Improvements to Care Management Requirements for Special Needs Plans (SNPs)

Generally, UCare does not have concerns with CMS's proposal to apply the chronic condition special needs plan (C-SNP) enrollee management and model of care (MOC) submission requirements to dual eligible SNPs (D-SNPs) and institutional SNPs (I-SNPs). However, we do have a few suggestions.

UCare recommends that CMS provide additional definitions and details about the interdisciplinary team. The proposed regulation (42 CFR § 422.101(f)) reads:

> In the management of care, use an interdisciplinary team that includes a team of providers with demonstrated expertise and training, and, as applicable, training in a defined role appropriate to their licensure in treating individuals similar to the targeted population of the plan.

UCare recommends that CMS clarify that "providers," as used in this section, follows the definition of "provider" in 42 CFR § 422.2. UCare also recommends that CMS provide additional details about what constitutes "demonstrated expertise and training." Specifically, are there minimal expertise or training requirements that the provider must meet or does each plan have discretion to make this determination? UCare would not support an interpretation of this language that would require the plan to provide training.

UCare does not have concerns about the proposal to provide face-to-face encounters with enrollees, because this is our current practice.

Although MOCs require significant work for plans, especially when more than one MOC is submitted based on multiple SNPs, we agree with CMS's rationale for proposing these additional MOC requirements for D-SNPs and I-SNPs. That said, we are concerned this may be a slippery slope to requiring D-SNPs and I-SNPs to submit the MOC annually, which UCare would not support.

Beneficiaries' Education on Opioid Risks and Alternative Treatments

UCare believes this is important information for enrollees to receive, and we support this initiative. We recommend that CMS add a separate section in the Evidence of Coverage (EOC) and the Annual Notice of Change (ANOC) to call this information out to all enrollees. We also recommend that CMS give health plans flexibility to provide information in the EOC and ANOC that targets subsets of the plans' enrollee population.

Eligibility for Medication Therapy Management Programs (MTMPs)

UCare recommends that CMS treat these enrollees as "expanded eligibility members" for the MTMPs. This would help ensure that health plans are not disincentivized from enrolling these enrollees into a Drug Management Program to avoid a negative impact to plans' comprehensive medication review rates.

Suspension of Pharmacy Payments Pending Investigations of Credible Allegations of Fraud and Program Integrity Transparency Measures

UCare recommends that CMS consider prescriber specialties when creating definitions or criteria for inappropriate prescribing.

Reinsurance Exceptions

UCare supports the additional flexibility provided under this arrangement and agrees that $10,000 is a reasonable level. UCare recommends that CMS allow additional flexibility to achieve a $10,000 actuarially equivalent attachment point, such as first dollar coverage for a subset of covered services (i.e., Part B drugs). UCare also recommends that CMS monitor this change to

ensure that this approach is not used by large national plans to financially underwrite smaller entities to use their Star ratings.

Out-of-Network Telehealth at Plan Option

UCare supports CMS's proposal to allow Medicare Advantage (MA) plans to provide additional telehealth benefits (ATBs) through non-contracted providers. This ATB option will give our enrollees more choices for care, especially in rural areas where we may have a less than optimal number of contracted providers.

MA and Part D Prescription Drug Program Quality Rating System

Cut Point Methodology. UCare supports the addition of Tukey outlier deletion to the cut point methodology for the Stars program. We are ultimately in support of all methodology that assists in stabilizing rate targets year over year. This supports more structured intervention work at the health plan level.

Proposed Measure Additions. UCare does not support the addition of the HEDIS Follow-Up after Emergency Department Visit for Patients with Multiple Chronic Conditions measure for 2021 performance period. There is minimal clinical utility to this measure given the lag time between network plans knowing of an emergency department visit and being able to connect with the enrollee.

Non-Substantive Changes to Transitions of Care. UCare supports the changes for admission notification and receipt of discharge information to two days and the inclusion of "patient instructions." Please consider clarifying that health plans are still limited to only what the primary care physician can access.

UCare is disappointed that the standalone Medication Reconciliation Post-Discharge (MRP) measure has not been retired. Double reviewing is a very burdensome process for medication reconciliation. CMS needs to release a retirement plan for the standalone MRP measure or consider removing it all together from the Transitions of Care measure.

Measure Weights. UCare does not support the weight increase from 2x to 4x for the patient experience, complaints and access measures in the Stars program. The increase undervalues Outcome measures and emphasizes factors outside of a health plan's control. We believe this

change will put too much weight on subjective measurements, and we have concerns with scenarios where we will be penalized unfairly (e.g., unhappy enrollees who chose a low-cost plan with network restrictions and less rich benefits).

Permitting a Second, "Preferred," Specialty Tier in Part D

UCare supports the second, preferred specialty drug tier. We agree that there needs to be a financial model that encourages use of lower cost, clinically effective specialty drugs, which is not currently in place. The current model favors rebate strategies. This additional specialty tier could generate health plan savings if manufacturers offer rebates for specialty drugs on a preferred tier, similar to how preferred non-specialty brand drugs are administered today. Health plans might also save on drug ingredient costs. We also encourage CMS to investigate alternative catastrophic reinsurance models to incentivize the most savings for health plans implementing a preferred specialty tier.

Beneficiary Real Time Benefit Tool (RTBT)

Although UCare supports this proposal, CMS must clarify the requirements for populating drugs on the RTBT. For example, for therapeutic alternative options, we would not realistically be able to populate every drug that could treat diabetes. Also, it would not be realistic to list alternatives for every nonformulary drug. If this proposal is finalized, UCare recommends that CMS develop an optional, model tool for all health plans to use. A CMS-developed tool could reduce costs for health plans and help ensure consistent functionality across health plans.

Medicare Advantage (MA) and Cost Plan Network Adequacy

UCare supports CMS's proposal to make health service delivery (HSD) reference files available in advance of network reviews. UCare recommends a process that allows health plans to provide feedback on county time and distance standard changes to ensure appropriate customization is consistent year after year. Plans have the clearest view of the localized provider supply, and CMS could team with health plans to develop appropriate county standards. Allowing CMS and health plans to tweak multiple aspects of the requirement, such as the percent of beneficiaries meeting the time and distance standards, will give our industry new tools to achieve fair monitoring.

UCare supports CMS's proposal to give plans a 10-percentage point credit towards the percentage of beneficiaries residing within the time and distance standards (for certain provider

specialty types) when the health plan contracts with one or more telehealth providers for those specified specialty types (Dermatology, Psychiatry, Cardiology, Neurology and Otolaryngology). If the adequate technology is available, UCare recommends that CMS add "Ophthalmology" and "Allergy and Immunology" to this list of provider specialty types.

When determining the credit, will CMS look at the relevance of the telehealth receiving site? For example, if a provider location offers both telehealth and in-person psychiatric services, the telehealth offering does not reduce travel distances and times, but it does make more appointments available. Would CMS offer the credit in this situation?

UCare suggests that CMS offer a 10-percentage point credit when telehealth services are present, but the services do not reduce travel distances and times and a 15-percentage point credit when they reduce travel distances and times. This could be monitored by plans submitting two HSD files. The first file would not include telehealth receiving site locations, and the second file would include telehealth receiving site locations. If the first file achieved at least 75% of the enrollees with access, CMS would offer the second submission and allow the plans to include the telehealth receiving site addresses and monitor for 90% of enrollees with access. We believe an additional credit is appropriate if the plan establishes telehealth services at a remote clinic that reduces the travel burden for enrollees.

Supplemental Benefit Requirements

UCare requests that CMS provide additional guidance on how health plans can ensure that allowance-based supplemental benefits meet the "primarily health related" requirement. Typically, enrollees have discretion in how they use these allowance-based dollars.

Requirements for Medicare Communications and Marketing

Examples. Although we understand that CMS is codifying longstanding policies and guidance currently found in its *Medicare Communications and Marketing Guidelines (MCMGs),* we do recommend that CMS add more examples to the definitions of "communications" and "marketing" to help provide consistency and clarity.

Open Enrollment Period. CMS specifically requested comments on how to implement prohibitions related to health plan marketing during the open enrollment period (OEP). UCare suggests that CMS provide specific examples of language health plans can and cannot use during

OEP. For example, would the use of the word "shop" in an unsolicited mailing that does not otherwise mention the OEP be considered a violation of OEP requirements? Also, health plans are currently allowed to include general information on their website about enrollment periods, including the OEP. UCare suggests that CMS provide optional, model language that qualifies as "general information" for use on health plan websites.

Sales Phone Lines. The MCMGs allow health plans to operate phone lines that are solely designated for sales and enrollment during business hours that differ from those required for customer service call centers. This policy does not appear to be codified in the proposed regulations. Is CMS eliminating this policy? See *MCMGs, § 80.1 - Hours of Operation for Telephone Lines Solely Designated for Sales and Enrollment*.

*Non-Renewal Notice*s. The proposed regulation (42 CFR § 422.2267(e)(10)) regarding non-renewal notices reads:

> Notice must be provided at least 90 calendar days before the date on which the nonrenewal is effective. For contracts ending on December 31, the notice must be dated October 2 to ensure national consistency in the application of Medigap Guaranteed Issue (GI) rights to all enrollees, except for those enrollees in special needs plans (SNPs).

The regulatory text does not address the earliest date that health plans may release this information, but the MCMGs do state:

> Information about non-renewals or service area reductions may not be released to the public, including current enrollees, until notice is received from CMS.

See *MCMGs, § 100.4 – List of Required Materials*. If this will continue to be the process, CMS could codify the process in the regulatory text. However, UCare suggests that CMS simply codify the earliest date that health plans may release this information. This would simplify the process and allow health plans to prepare for the mailing.

Subregulatory Guidance. Finally, although we appreciate CMS's steps to codify communications and marketing policies in regulations, we note that the MCMGs are a valuable tool, especially for health plan staff who are not accustomed to reading federal regulations. We strongly encourage CMS to continue to provide policy interpretations, examples and best practices in the easier to digest MCMGs.

Special Election Periods (SEPs) for Exceptional Conditions

SEP for Employer/Union Group Health Plan (EGHP) elections. Proposed 42 CFR § 422.62(b)(4) codifies the SEP for EGHP elections and reads:

> (4) The individual is making an MA enrollment request into or out of an employer sponsored MA plan, is disenrolling from an MA plan to take employer sponsored coverage of any kind, or is disenrolling from employer sponsored coverage (including COBRA coverage) to elect an MA plan. This SEP is available to individuals who have (or are enrolling in) an employer or union sponsored *MA plan* and ends 2 months after the month the employer or union coverage of any type ends. The individual may choose an effective date that is not earlier than the first of the month following the month in which the election is made and no later than up to 3 months after the month in which the election is made. (*emphasis added*.)

According to the *Medicare Managed Care Manual, Chapter 2 - MA Enrollment and Disenrollment, Section 30.4.4,* "this SEP is available to individuals who have (or are enrolling in) an employer or union sponsored plan and ends 2 months after the month the employer or union coverage ends." The manual does not require that the employer or union sponsored plan be "an employer or union sponsored MA plan." UCare suggests that CMS modify the proposed language so that it follows the manual language. UCare also suggests that CMS either add a definition of "employer sponsored coverage" or clarify that the employer sponsored coverage can be through the individual's own employer, the individual's spouse or the individual's domestic partner.

Continuous SEP for full-benefit dual eligible (FBDE) enrollees. UCare strongly believes CMS needs to reinstate a continuous SEP for FBDE enrollees. This is needed to simplify and allow more flexibility for health plans, including Minnesota's two dual eligible special needs plans (D-SNPs): the legacy (since 1997) Minnesota Senior Health Options (MSHO) and Special Needs Basic Care (SNBC). Individuals enrolling in these plans are either 65 years or older (MSHO) or people with disabilities aged 18-64.

In 2019, CMS changed its policy around the frequency that "at-risk" enrollees were permitted to change plans. Federal regulations (42 CFR § 423.100) define "at-risk" as those identified at risk of misuse or abuse of frequently abused drugs covered under Part D plans. With this change in policy, Minnesota's D-SNP enrollees went from being able to enroll in/disenroll from a D-SNP

plan each month, to being limited to changing plans each quarter for Q1-Q3 within a calendar year, and according to annual election period timelines during Q4 of each year.

We assert this change has placed undue burden on, and unnecessarily introduced administrative complexity for, all stakeholders of Minnesota's D-SNPs, including: enrollees and caregivers who help make health insurance decisions; county staffs who administer eligibility for Minnesota's Medicaid program for aged, blind and disabled populations; providers who serve these enrollees and must track enrollment/eligibility; Minnesota's Medicaid agency, which works closely with its contracted integrated D-SNPs and counties, toward a seamless, enrollee-friendly, integrated enrollment process for these enrollees; and finally, health plans, such as UCare, which offer D-SNPs in Minnesota. Adding the limitations on changing plans has added to the complexity aged and disabled FBDE enrollees already face related to health care eligibility and enrollment (e.g., this limitation adds a another, unnecessary layer to the existing complexity of maintaining Medicaid eligibility).

We believe our Medicaid agency engaged with CMS over the past two years to discuss/demonstrate to CMS that there was no evidence of any level of negatively-driven plan changing by "at-risk" enrollees enrolled in Minnesota's D-SNPs. We believe the Medicaid agency has tried to communicate to CMS the negative effect this policy would have, and has had, on Minnesota's programs. We maintain that Minnesota's programs have become more difficult to explain, understand and administer since the continuous special election period for full benefit dual eligibles was removed – without any positive impact on the program.

To return to more streamlined programs for these elderly populations and people with disabilities, we request CMS update its policy to re-create a continuous SEP for enrollment in and out of Minnesota's (and other states) for fully integrated dual eligible (FIDE) SNP (MSHO) and highly integrated dual eligible (HIDE) SNP (SNBC) plans.

Exclusion of Services Furnished Under a Private Contract

UCare supports the proposed changes to 42 CFR § 422.220 that will allow health plans to make payments for supplemental benefits to physicians and practitioners who opt out of Medicare. We agree that payments for supplemental benefits are outside the scope of the statutory restriction on payments to opt-out providers.

Disclosure Requirements

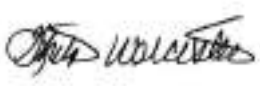
UCare understands that CMS is codifying current explanation of benefits (EOB) requirements, but we would like CMS to take this opportunity to provide health plans with more flexibility in the timing of the EOB. Plans must either send the EOB on a monthly cycle or a quarterly cycle with per-claim notifications. UCare suggests that CMS allow health plans to send the EOB every two weeks. Health plans use the EOB to satisfy enrollee notification requirements, so sending the EOB only on the monthly or quarterly cycle does not always allow health plans to meet these notification timeframes. See CMS's *Medicare Managed Care Manual, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Section 40.12.1 – Part C Notification Requirements*.

Definition of "Institutionalized" for Institutional Special Needs Plans (I-SNPs)

UCare supports the proposal to modify the definition of "institutionalized." This definition reconciles differences in the guidance and the regulatory text that have caused confusion about the open enrollment period for institutionalized individuals. We also support the new criteria that allows CMS to include additional facilities in the definition of "institutionalized" as forms of institutional care change.

Thank you for considering the above comments and recommendations.

Sincerely,



Ghita Worcester
Senior Vice President, Public Affairs and Chief Marketing Officer
UCare

TAB 3

PUBLIC SUBMISSION

As of: January 25, 2024
Received: April 06, 2020
Status: Posted
Posted: April 10, 2020
Tracking No. 1k4-9fz2-k2di
Comments Due: April 06, 2020
Submission Type: Web

Docket: CMS-2020-0010
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2021 (CMS-4190-P)

Comment On: CMS-2020-0010-0002
Medicare and Medicaid Programs: Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Document: CMS-2020-0010-0390
Comment on CMS-2020-0010-0002

Submitter Information

Name: Dan Elling
Organization: SCAN Health Plan

General Comment

On behalf of SCAN Health Plan, please accept the following comments pertaining to the proposed technical changes to MA and Part D for CY2021 and 2022.

Attachments

04.06.20. SCAN Health Plan Comment Letter Part C and D for CY2021 and 2022

3800 Kilroy Airport Way
Suite 100, P.O. Box 22616
Long Beach, CA 90801-5616

TEL 562.989.5100
FAX 562.989.5200

VIA ELECTRONIC SUBMISSION: **http://regulations.gov**

April 6, 2020

The Honorable Alex Azar
Secretary, Department of Health & Human Services

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services

Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4–26–05
Baltimore, MD 21244–1850

Re: SCAN Health Plan Comments on CMS–4190

Dear Secretary Azar and Administrator Verma:

SCAN Health Plan (SCAN) is pleased to submit comments in response to ***the Medicare and Medicaid Programs: Contract Year (CY) 2021 and 2022 Policy and Technical Changes to the Medicare Advantage (MA) Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly.*** The following includes background on SCAN and comments on selected provisions in the proposed rule.

SCAN applauds the Administration for its leadership in developing policies that improve the health care of Medicare beneficiaries, including those who are vulnerable and have complex conditions. SCAN also appreciates the Administration's efforts to address the COVID-19 pandemic. Because COVID-19 is especially fatal for older adults with underlying health conditions, SCAN is working diligently to ensure that our members (all of whom are MA beneficiaries) remain informed and healthy. We provide updated COVID-19 information on our website, https://www.scanhealthplan.com/members/coronavirus-information, and outreach to our members and the community. Efforts include calling members directly to check on their health, providing emergency funding for nonprofits, and offering a resource and referral line to support seniors and family caregivers. For more details on SCAN's COVID-19 activities, please go to: https://www.scanhealthplan.com/about-scan/press-room/april-2020/applauding-governor-newsoms-call-to-protect-california-seniors-scan-health-plan-expands.

I. SCAN Health Plan

SCAN is a nonprofit health plan serving over 200,000 Medicare beneficiaries in California and the third largest nonprofit Medicare Advantage Prescription Drug (MA-PD) plan in the country. Since 1985, SCAN has specialized in providing comprehensive, high quality care to the most vulnerable Medicare beneficiaries, including those who live with multiple chronic conditions, who are eligible for nursing home care, and who have difficulty performing activities of daily living. For beneficiaries who require additional

attention, SCAN offers institutional, chronic care, and dual eligible special needs plans (SNPs). SCAN is proud to have earned a 4.5 star rating on a five-point scale from the Centers for Medicare & Medicaid Services (CMS) in each of the last three years and named one of the best insurance companies for MA in California by *U.S. News and World Report* for the second straight year.

II. SCAN Comments on Selected Provisions

Implementation of Certain Provisions of the Bipartisan Budget Act (BBA) of 2018

Special Supplemental Benefits for the Chronically Ill (SSBCI) *(§ 422.102),* p. 9011[1]

- CMS Proposal: CMS proposes codifying in regulation existing SSBCI sub-regulatory guidance and statutory parameters. This includes defining SSBCI and chronic condition, allowing plans to apply SSBCI to chronic conditions that are not on the list established by the panel of clinical advisors, requiring plans to make information related to determining enrollee eligibility available to CMS upon request, and clarifying that SSBCI benefits determination is subject to the MA grievances and appeals rules.

- SCAN Comments: SCAN supports codifying existing SSBCI sub-regulatory guidance and statutory parameters in regulation and waiving the uniformity rule to provide individualized services. We also appreciate the decision to refrain from requiring a physician's orders to provide supplemental benefits.

Improvements to Care Management Requirements for SNPs *(§ 422.101),* p. 9013

- CMS Proposal: CMS proposes implementing new statutory requirements for SNPs with respect to enrollee care management (applies to interdisciplinary team composition and annual face-to-face encounters) and model of care (MOC) standards (requires assessments to be incorporated in the individualized care plan). It also requires CMS to consider MOC performance against prior year goals and CMS benchmarks when considering whether to approve an MOC.

- SCAN Comments: SCAN strongly supports providing individualized care plans. However, we believe that requiring annual SNP face-to-face encounters would negatively affect beneficiaries and be challenging plans to implement.

  Individual Care Plans. SCAN supports individualized care plans, as they provide a coordinated and agreed-upon plan and maintain a list of problem areas to consider for high quality care management. We agree that care plans should include areas of risk identified during the initial and annual health risk assessment and be person-centered. They should include the problems, goals, and interventions that the beneficiary is willing and able to address with the support of his/her interdisciplinary team. SCAN does not support adding items to the care plan not agreed to by the beneficiary because it violates the trust between the beneficiary and the care team. Further, a requirement to include risks that the beneficiary does not want to address is counterproductive to person-centeredness.

[1] Page numbers of provisions refer to the proposed rule included in the Federal Register: https://www.federalregister.gov/documents/2020/02/18/2020-02085/medicare-and-medicaid-programs-contract-year-2021-and-2022-policy-and-technical-changes-to-the

Face-to-Face Encounters. SCAN does not support a requirement for face-to-face encounters for SNPs. SNP members have varying degrees of complexity, which makes face-to-face encounters difficult for some members and geographies. This requirement also does not take into account beneficiary preference and capability. For example, although SCAN supports using tele-connected care, many of our beneficiaries do not have that capability (phone is easier and more uniformly acceptable for some beneficiaries). Additionally, face-to-face encounters would be difficult to track if conducted by the provider and not the plan. SCAN believes that plans' limited resources would be better utilized reserving face-to-face encounters for helping the neediest of the SNP population.

Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes *(§ 422.514),* p. 901

- CMS Proposal: CMS proposes not approving or renewing contracts for "D-SNP look-alike" MA plans, except in states that have no D-SNPs or other plans authorized by CMS to exclusively enroll duals (such as Medicare Medicaid demonstration plans). CMS would: 1) permit affected plans that have approved D-SNPs for the following plan year to transition members to those D-SNPs and 2) define "look-alike" for bid purposes as a plan that projects its enrollment to be 80 percent or more duals, or in the current year has actual enrollment of 80 percent or more duals (with exceptions for new plans with fewer than 200 enrollees).

- SCAN Comments: SCAN strongly supports integration and development of the MOC for D-SNP "look-alikes," but disagrees with limiting enrollment to states that have no D-SNPs or other plans authorized by CMS to exclusively enroll duals (such as Medicare Medicaid demonstration plans). Alternatively, SCAN recommends a federal level solution that applies to all states and takes a more deliberate approach to help "look-alikes" progress. Another suggestion is for CMS to slow down the timing of phasing out D-SNP "look-alikes." This would reduce state burden because not all contracts would have to be in place at one time and allow plans more time to make alternative arrangements for members.

    - *Integration Pathway.* SCAN recommends creating an integration path for "look-alike" plans and requiring them to provide MOCs. SCAN requests that CMS not identify these plans as "look-alikes," but rather as uncoordinated plans on a pathway to greater integration, such as D-SNPs evolving into a Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP) or Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP).
    - *MOCs.* SCAN supports plans coordinating care, but not requiring them to have a state Medicaid contract. Plans should have a MOC that outlines how they would coordinate benefits for duals and take on more responsibility. CMS could also require these plans to offer enhanced benefits above what the beneficiary would be able to get with Medicare and Medicaid.
    - *Beneficiary Choice.* SCAN supports giving beneficiaries a choice to enroll in high quality plans whether they are integrated or not. In some areas, the integrated options offered have lower quality (lower Star ratings) than non-integrated plans. We believe that if a "look-alike" plan offers a higher quality product than other plans in the area and better access to a larger network of high-quality providers, then beneficiaries should be able to continue in the plan of their choice. In brief, if CMS' is interested in moving beneficiaries into high quality plans, then this proposal runs counter to this goal.

Implementation of Several Opioid Provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities First

Beneficiaries with History of Opioid-Related Overdose Included in Drug Management Programs *(§ 423.100),* p. 9025

- CMS Proposal: CMS proposes to define ''history of opioid-related overdose'' to mean that for the Part D beneficiary, a recent claim has been submitted that contains a principal diagnosis code reflecting an opioid overdose, regardless of the type of opioid and at least one recent prescription drug event for an opioid dispensed.

- SCAN Comments: SCAN recommends expanding the ICD-10-CM to divide the Z91.5 code to describe cause of self-harm. Currently, there is no way to identify the cause/method of historical suicide attempts. This is important to know because if the patients were SCAN members, we would have data indicating their hospitalization was for an opioid overdose. If they were not members, we would only know they had a past suicide attempt with the method unknown, and potentially miss members who should be included in the mandatory drug management plan. SCAN recommends that the code for history of a suicide attempt be further defined to include the method of suicide attempt.

Suspension of Pharmacy Payments Pending Investigations of Credible Allegations of Fraud and Program Integrity Transparency Measures *(§§ 405.370, 422.500, 422.503, 423.4, 423.504, and 455.2)*, p. 9033

- CMS Proposal: CMS proposes allowing MA organizations and Medicare Part D plan sponsors (including MA organizations offering MA–PD plans) to share data and information regarding bad actors and suspend payment if an investigation shows a credible allegation of fraud.

- SCAN Comments: SCAN recommends that CMS provide training programs for health plan fraud units and guidance regarding the definition of a credible allegation. Most plans do not have experience in these types of cases (not related to contract provisions).

Enhancements to the Part C and D Programs

MA and Part D Prescription Drug Program Quality Rating System *(§§ 422.162, 422.164, 422.166, 422.252, 423.182, 423.184, and 423.186),* p. 9043

- CMS Proposal: CMS proposes several changes to the Star ratings program, including:
  - Cut point methodology for non- Consumer Assessment of Healthcare Providers & Systems (CAHPS) measures by removing outliers.
  - Substantive updates to the specifications of Health Outcomes Survey (HOS) measures (Improving or Maintaining Physical Health and Improving or Maintaining Mental Health).
  - New Part C measure to the Star ratings program (Transitions of Care).
  - Weight of patient experience/complaints/access measures from 2 to 4.
  - Extreme and uncontrollable circumstances policy.

- SCAN Comments: SCAN recommends the following regarding specific Star rating proposals: 1) revising the cut point methodology for non-CAHPS measures by removing outliers, 2) increasing the weight of patient experience/complaints/access measures from 2 to 4, and 3) adding a new Part C measure to the Star ratings program (i.e., Transition of Care).

Cut Point Methodology for Non-CAHPS Measures, p. 9043

- CMS Proposal: SCAN proposes revising the cut point methodology for non-CAHPS measures by removing outliers.

- SCAN Comments: SCAN appreciates CMS' proposal to include outlier removal and guardrails in the threshold calculation. These methodologies will likely improve stability, but not predictability. We recommend that CMS use previous year Star rating data to develop and publish thresholds prior to the measurement year begins or at least before the measurement year ends. SCAN also recommends that CMS publish the resulting thresholds and impacts of the new methodology using the most recent Star rating data. In the federal registry, CMS uses CY2018 Star rating (2016 measurement year) data for their impact analysis, which is at least two years old.

Substantive Updates to the Specifications of HOS Measures, p. 9045

- CMS Proposal: CMS proposes implementing substantive updates to the specifications of HOS measures (Improving or Maintaining Physical Health measure and Improving or Maintaining Mental Health measure). These include modifying the case-mix adjustment and increasing the minimum required denominator from 30 to 100.

- SCAN Comments: SCAN recommends that CMS perform simulations to evaluate the performance of the new case-mix adjustment methodology (i.e., use complete data set; randomly select records as missing and compare them with the new and existing methodology; and consider whether the missing data is random or not) before implementing.

New Part C Measure to the Star Ratings Program (Transitions of Care), p. 9046

- CMS Proposal: CMS proposes adding two new Part C measures to the Star ratings program (Transitions of Care and Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions).

- SCAN Comments: SCAN questions what the new Transition of Care measure means because it is composed of four sub-measures. In the Display measure, CMS uses the average of four sub-measures which is inconsistent with the National Committee for Quality Alliance (NCQA). We disagree that the NCQA changes are non-substantive and recommend that CMS maintain the updated NCQA transition of care measure in Display for another two years before moving to Star rating.

Weight of Patient Experience/Complaints and Access Measures, p. 9049

- CMS Proposal: CMS proposes increasing the weight of patient experience, complaints, and access measures from 2 to 4.

- SCAN Comments: SCAN strongly disagrees with increasing the weights of patient experience, complaints, and access measures from 2 to 4 for a few reasons. The first is that weighing these measures to 4 is higher than the Intermediate Outcome Measures. We believe this sends the wrong message to MA plans, providers, and Medicare beneficiaries that patient experience is more important than outcomes. For example, this increase makes patient experience four times more important than many preventive care measures. However, the literature shows that preventive

screenings, such as colorectal cancer screening, can save lives. SCAN is concerned that this increase would lead to unintended consequences such as MA plans and providers not focusing on these preventive measures or consistently reminding patients about these important screenings.

Another concern is that many patient experience and access measures have small denominators and high variation. Member satisfaction measures are based on the CAHPS survey of 800 members. Based on the sample size and response rate, the lower and upper bound of confidence intervals could cover up to three measure Star ratings. However, survey measures such as member satisfaction based on CAHPS have limitations. Some member satisfaction measure scales assume the response are ratio scale (e.g., "Always" is 4 and "Usually" is 3; however, is "Always" 25% easier or more satisfied than "Usually")? Finally, these weights were recently increased from 1.5 to 2.0 for Star rating 2021. SCAN strongly encourages CMS to evaluate the impact of the proposed weight increase before implementing.

Extreme and Uncontrollable Circumstances Policy *(§§ 422.166(i), 423.186(i))*, p. 9049.

- CMS Proposal: CMS is soliciting comments on current disaster relief policy for treatment of multiple year-affected contracts.

- SCAN Comments: SCAN appreciates that CMS is taking into account the disruption to data collection due to the COVID-19 pandemic and assigning CY2020 scores and Star ratings for HEDIS, CAHPS, and other administrative measures, including the "Extreme and Uncontrollable Circumstances policy." However, we ask that CMS use the final score and Star rating instead of the raw or unadjusted ones.

  Unlike previous "Extreme and Uncontrollable Circumstances Policy" adjustments, which is the higher of current year or prior year scores and Stars, under the current circumstances, CMS will only use the prior year, which is the CY2020 score and Star. Because, as CMS has acknowledged, scores are impacted negatively by major disasters for plans with more than 25% of their members (in our case more than 40%) living in major disaster counties, SCAN requests that the scores be adjusted and based on CY2019 scores and Stars to better reflect a contract's performance. Therefore, we recommend that CMS use the CY2020 final score and Star for the CY2021 Star rating for impacted measures (HEDIS, CAHPS, etc.).

Second "Preferred", Specialty Tier in Part D *(§§ 423.104, 423.560, and 423.578),* p. 9051

- CMS Proposal: CMS proposes establishing a second "preferred" specialty tier at a lower cost-sharing threshold than the current specialty tier. In addition, Part D sponsors would be required to permit tiering exceptions between the two specialty tiers. CMS is also soliciting comments on the potential for permitting the higher cost-sharing specialty tier to exceed the maximum cost sharing currently permitted (25/33%), a maximum allowable cost sharing of 25% without regard to deductible, and whether to set a numeric or other differential in cost sharing between the specialty tiers.

- SCAN Comments: SCAN supports CMS' efforts to allow Part D sponsors flexibility in benefit design and believes that a proposed "preferred" specialty tier has potential for cost savings to beneficiaries and sponsors over time. A second specialty tier would allow plans to negotiate greater discounts from drug manufacturers for preferred status, similar to non-specialty drugs. However, additional changes would be needed for Part D sponsors to take full advantage of this preferred

specialty tier. If CMS adopts a preferred specialty tier, plans should be allowed to have higher cost sharing on the non-preferred specialty tier and have higher cost sharing if there is no deductible.

For the preferred specialty tier to be meaningful to beneficiaries and extract greater discounts from drug manufacturers, the non-preferred specialty tier needs to have higher cost sharing so there is a sufficient differential between the preferred specialty tier and higher specialty tier. If CMS adopts the proposal without allowing changes to cost sharing, plans would not have the necessary leverage to negotiate greater discounts from drug manufacturers. This could result in having fewer plans implement a preferred specialty tier.

In addition, SCAN does not agree with changing the maximum cost sharing of 25% without regard to deductibles. The existing rules allow plans flexibility in benefit design. CMS' should reconsider allowing tier exceptions between the two specialty tiers and a higher cost sharing amount for the higher tier.

Beneficiary Real Time Benefit Tool (RTBT) *(§ 423.128),* p. 9059

- CMS Proposal: CMS proposes that sponsors implement a beneficiary RTBT that would allow enrollees to view information such as formulary and benefit information, cost sharing, formulary alternatives, and utilization management requirements. The information should be available through a patient portal or computer application.

- SCAN Comments: Though the proposal has good intentions, SCAN disagrees with implementing a beneficiary RTBT. Existing tools like Medicare Plan Finder along with formulary and benefit information published on plan websites serve the same purpose. Beneficiaries currently have the tools to determine how much their drugs will cost at their pharmacy of choice, access to formulary and utilization management criteria, and cost sharing of their medications.

  SCAN supports CMS' efforts to promote price transparency, but we believe that the prescriber RTBT would have the greatest impact on lowering beneficiary costs. Providers need to use beneficiary cost sharing information when selecting and initiating treatment. We encourage CMS to implement an incentive program that would allow providers to earn payments for utilizing RTBT while those who do not utilize RTBT are subject to a payment adjustment, similar to the approach used to encourage adoption of electronic prescribing.

Establishing Pharmacy Performance Measure Reporting Requirements *(§ 423.514),* p. 9063

- CMS Proposal: CMS proposes that sponsors disclose to CMS the pharmacy performance measures used to evaluate pharmacy performance. CMS would publish the list of measures to increase public transparency.

- SCAN Comments: SCAN appreciates CMS' interest in public transparency for pharmacy measures. However, we believe that the existing Part D reporting framework is sufficient for this process. We do not believe that having a consensus set of measures for plans to choose from, solely relying on third parties for development of measures, or publishing the list of pharmacy

performance measures publicly for the sake of public transparency, is in the best interest of Medicare beneficiaries.

We also disagree with requirements that only use specific quality measures adopted by CMS or third parties because it often takes years before these quality measures are approved. As a result, this requirement would stifle plan flexibility and innovation. Plans would not be able to measure pharmacies for quality measures that are not in existence today or for clinical quality beyond existing 5-Star measures.

Finally, SCAN does not believe that publishing the list of pharmacy performance measures would result in any meaningful transparency. Currently, many plans can develop their own measures that are specific to their goals, and having this information available publicly would put plans in a competitive disadvantage. Also, plans would have a harder time innovating and differentiating themselves from other plans. SCAN supports CMS collecting pharmacy measures that are being used by plans and to review fairness and improve medication use or outcomes.

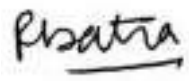
Dismissal and Withdrawal of Medicare Part C Organization Determination and Reconsideration and Part D Coverage Determination and Redetermination Requests *(§§ 422.568, 422.570, 422.582, 422.584, 422.590, 422.592, 422.631, 422.633, 423.568, 423.570, 423.582, 423.584, and 423.600),* p. 9069

- CMS Proposal: CMS proposes establishing processes for the withdrawal or dismissal of: (i) Part C organization determination and reconsideration requests; (ii) Part D coverage determination and redetermination requests; and (iii) Part C and Part D independent review entity (IRE) reconsiderations.

- SCAN Comments: SCAN supports establishing processes that clarify the above proposed guidelines.

Thank you for the opportunity to submit comments on this proposed rule. SCAN truly appreciates your commitment to improving the health of older adults and vulnerable populations. Please do not hesitate to contact me at rbatra@scanhealthplan.com, if you would like additional information.

Sincerely,



Romilla Batra, MD
Chief Medical Officer
SCAN Health Plan

TAB 4

PUBLIC SUBMISSION

As of: January 25, 2024
Received: April 06, 2020
Status: Posted
Posted: April 10, 2020
Tracking No. 1k4-9fz3-2uzj
Comments Due: April 06, 2020
Submission Type: Web

Docket: CMS-2020-0010
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2021 (CMS-4190-P)

Comment On: CMS-2020-0010-0002
Medicare and Medicaid Programs: Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Document: CMS-2020-0010-0399
Comment on CMS-2020-0010-0002

Submitter Information

Name: Christine Lynch
Address:
Washington, 20005
Email: clynch@communityplans.net
Organization: ACAP

General Comment

See attached file(s)

Attachments

ACAP Comment Letter on 2021_2022 Proposed Rule_Final

Association for Community Affiliated Plans

1155 15th Street, N.W., Suite 600 • Washington, DC 20005
202.204.7508 • www.communityplans.net
Christopher D. Palmieri, Chair • Margaret A. Murray, Chief Executive Officer

April 6, 2020

Demetrios Kouzoukas
Principal Deputy Administrator & Director, Center for Medicare
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Submitted via electronic submission system

Re: Contract Year 2021 and 2022 MA-PD Proposed Rule

The Association for Community Affiliated Plans (ACAP) greatly appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the Contract Year 2021 and 2022 MA-PD Proposed Rule. ACAP is an association of 74 not-for-profit, community-based Safety Net Health Plans located in 29 states. Our member plans provide coverage to over twenty million individuals enrolled in Medicaid, Children's Health Insurance Program (CHIP) and Medicare Advantage Dual-Eligible SNPs. Twenty of our plans are D-SNPs and nationally, ACAP plans serve approximately one out of every four Medicaid managed care enrollees.

We submit the following comments for CMS' consideration.

- ***Star Ratings and Socioeconomic Status***: In order to address the impact of SES on the Star Ratings and to level the playing field for D-SNPs, CMS should evaluate peer grouping the Star Ratings so that D-SNPs are compared to each other in the Star Rating system.

- ***D-SNP Look-Alikes***: ACAP supports CMS' proposal to not renew or enter into new contracts with D-SNP look-alikes. However, the proposed 80 percent threshold is too high, and we suggest CMS lower the threshold.

- ***Special Supplemental Benefits for the Chronically Ill***: We support CMS' proposal to broaden the list of chronic conditions eligible for SSBCI. We also support CMS' proposals to remove the specification that incurred claims are payments to providers for covered services and to permit claims for supplemental benefits to be included in the MLR numerator as Quality Improvement Activities.

- ***SNP Care Coordination Activities***: We would appreciate additional information on the intended benefits to the beneficiary that CMS expects from requiring annual face-to-face encounters beyond what D-SNPs are already providing their members.

- ***ESRD Beneficiaries Enrolling in MA***: We ask CMS to monitor enrollment of beneficiaries with ESRD into D-SNPs and ensure that payments to D-SNPs for their ESRD members are adequate.

Star Ratings

ACAP believes in the need for an accurate quality measurement system for all MA plans, including those who exclusively serve dual-eligible beneficiaries. As CMS is aware, the Star Rating system is currently not a level playing field for D-SNPs, because the ratings do not adjust for the impact of dual-eligible status or other social risk factors. This results in a structural disadvantage for plans serving dual-eligible beneficiaries. As CMS also knows, the December 2016 ASPE Report to Congress found that dual status is a significant predictor of poor-quality ratings, independent of plan or provider performance. However, an effective adjustment has still not been made to the Star Rating system to remove the effect of dual status and other social risk factors on D-SNPs quality scores.

Although the impact of SES on Star Ratings was not addressed in this Proposed Rule, we nevertheless encourage CMS to develop a meaningful, long-term adjustment to the Star Rating system to level the playing field for D-SNPs. Specifically, we are asking CMS to evaluate peer grouping the Star Ratings for D-SNPs as a long-term strategy to address the impact of dual-eligible enrollment on Star Ratings. There is already a precedent for CMS using peer grouping in a quality rating system. The agency currently uses peer grouping in the hospital quality rating system by placing hospitals into quintiles based on their proportion of dual-eligible patients. We ask that CMS maintain consistency in its approach to quality measurement by using peer grouping for D-SNPs in the Star Rating system. We note that for this to occur, Star Ratings will likely have to be reported at the plan level. In addition to peer grouping, we also ask CMS to evaluate using measures that are appropriate for the dual-eligible population. The Star Rating system should incorporate measures that consider the unique needs of dual-eligible beneficiaries with complex health, behavioral, and cognitive conditions and whose care is affected by socioeconomic challenges.

Regarding the proposed changes to the Star Rating system, we do not support increasing the weight of the Patient Experience and Complaints and Access measures from 2 to 4. This change would increase the proportion of these measures to a plan's Star Rating from 37 percent to 53 percent. Although patient experience is an important indicator, we do not believe that members' self-

reported experience should outweigh their actual health outcomes. We also ask CMS to no longer down-weight the responses from dual-eligible beneficiaries on some CAHPs measures.

Regarding CMS' proposed outlier policy, we support the proposal to reduce the influence of outliers on the Star Rating cut points.

D-SNP Look-Alikes

ACAP shares CMS' concern about the proliferation of D-SNP look-alikes and the impact of those plans on enrollment in integrated care programs for dual eligibles. We support CMS' proposal to not renew or enter into new contracts with D-SNP look-alikes. However, the proposed 80 percent threshold to use in identifying D-SNP look-alikes is too high and will result in CMS not identifying all D-SNP look-alikes. Instead, we suggest CMS lower the threshold, such as to 40 or 50 percent. Additionally, we recommend that CMS exclude partial-benefit dual eligibles from the calculation of the threshold in order to enable the identification of a D-SNP look-alike to be based on a plan's enrollment of full-benefit dual eligibles. We also recommend that CMS consider defining D-SNP look-alikes as MA organizations that have a D-SNP and MA-PD under the same contract, with the majority (i.e. 50 percent or more) of dually eligible beneficiaries enrolled in the MA-PD, rather than the D-SNP.

Special Supplemental Benefits for the Chronically Ill

ACAP believes that SSBCI is an important tool for MA plans to tailor extra benefits for their chronically ill members. As such, we support CMS broadening the list of chronic conditions eligible for SSBCI. We also support CMS' proposals to remove the specification that incurred claims are payments to providers for covered services and to permit claims for supplemental benefits to be included in the MLR numerator as Quality Improvement Activities.

SNP Care Coordination Requirements

ACAP believes that care coordination is a key benefit D-SNPs provide their enrollees. Regarding CMS' proposal for all SNPs to conduct an annual face-to-face encounter with each enrollee, we would appreciate additional information on the intended benefits to the beneficiary that CMS expects from this policy beyond what D-SNPs are already providing their members. Additionally, with respect to the requirement that encounters be in-person or through visual, interactive telehealth,

CMS should note that not all dually eligible beneficiaries have access to visual, interactive telehealth technology.

ESRD Beneficiaries Enrolling in MA

With respect to enrollment of individuals with ESRD into MA plans, we note that there may be a higher prevalence of ESRD among the dually eligible population. As such, a disproportionate share of beneficiaries with ESRD could be enrolling in D-SNPs. We ask CMS to monitor enrollment of beneficiaries with ESRD into D-SNPs and ensure that payments to D-SNPs for their ESRD members are adequate.

Conclusion

ACAP is prepared to assist with additional information, if needed. If you have any questions, please do not hesitate to contact Christine Aguiar Lynch at (202) 204-7519 or clynch@communityplans.net.

Sincerely,

Margaret A. Murray
Chief Executive Officer

TAB 5

PUBLIC SUBMISSION

As of: January 25, 2024
Received: April 06, 2020
Status: Posted
Posted: April 10, 2020
Tracking No. 1k4-9fz4-g27g
Comments Due: April 06, 2020
Submission Type: Web

Docket: CMS-2020-0010
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2021 (CMS-4190-P)

Comment On: CMS-2020-0010-0002
Medicare and Medicaid Programs: Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Document: CMS-2020-0010-0414
Comment on CMS-2020-0010-0002

Submitter Information

Name: Sarah Rayel
Address:
Washington, DC, 20005
Email: sarah.rayel@bcbsa.com
Organization: Blue Cross Blue Shield Association

General Comment

Thank you for the opportunity to comment. Please see attached for detailed comments from the Blue Cross Blue Shield Association (BCBSA).

Attachments

BCBSA Comment Letter on 2021 MA and Part D Proposed Rule_FINAL_with KH signature

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

1310 G Street, N.W.
Washington, D.C. 20005
202.626.4800
www.BCBS.com

April 6, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Submitted via the Federal Regulations Web Portal, http://www.regulations.gov

RE: CONTRACT YEAR 2021 AND 2022 POLICY AND TECHNICAL CHANGES TO THE MEDICARE ADVANTAGE PROGRAM, MEDICARE PRESCRIPTION DRUG BENEFIT PROGRAM, MEDICAID PROGRAM, MEDICARE COST PLAN PROGRAM, AND PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PROPOSED RULE; CMS-4190-P)

Dear Administrator Verma:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the Proposed Rule: Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage (MA) Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. (85 Fed. Reg 9002)

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively provide healthcare coverage for one in three Americans. For more than 90 years, Blue Cross and Blue Shield companies have offered quality healthcare coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid. Today, BCBS Plans serve millions of Medicare beneficiaries in MA and Part D options.

Overall, we support many of the provisions in the Proposed Rule and thank the Centers for Medicare & Medicaid Services (CMS) for its continued attention to policies that support the successful MA and Part D programs that millions of beneficiaries rely on for their Medicare benefits.

BCBSA and BCBS Plans are supporting beneficiaries and working in partnership with providers across the country during the COVID-19 pandemic. Amid growing concerns about the spread of the virus in communities across the country, Plans are taking steps to ensure enrollees have uninterrupted access to high-quality healthcare during this national emergency.

We applaud the agency for releasing the Interim Final Rule titled “Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health

Emergency." The release empowers local hospitals and healthcare systems to take action to address the crisis and takes important steps to maintain stability for the MA and Part D programs during disruption to the healthcare system. We appreciate all that CMS has done to date to address the impact of COVID-19 on the nation's healthcare systems, and we look forward to working with you throughout this public health emergency.

We would like to highlight several key issues and recommendations, discussed in more detail in the detailed comment letter below.

Key BCBSA recommendations on the Proposed Rule include:

- **Provide Part D sponsors with the flexibility to offer a preferred and non-preferred specialty tier in a way that reduces costs –** We appreciate CMS' proposal to allow for a second, preferred specialty tier. However, we are concerned that the proposal in its current form could lead to higher costs, which will lead to premium increases for beneficiaries. To avoid increases, we recommend that CMS modify the policy to allow plans to increase cost-sharing on the non-preferred specialty tier. This would provide Part D plan sponsors with additional tools to effectively negotiate the lowest prices with manufacturers in order to avoid premium increases and reduce costs for the Medicare program.

- **Strengthen Star Ratings to improve quality –** CMS should continue to focus the Star Ratings program on outcomes-based and objective clinical measures, rather than process measures and subjective non-clinical measures.

- **Broaden "extreme and uncontrollable circumstances" policy in Star Ratings to recognize all disasters that impact plans – I**n order to ensure plans aren't penalized for events completely outside of their control, CMS should expand the definition of "extreme and uncontrollable circumstances" to consider scenarios beyond natural disasters, such as the current COVID-19 pandemic, as well as state public health emergencies, when the Health and Human Services (HHS) Secretary declares a public health emergency, or in the event of a Federal Emergency Management Agency (FEMA) emergency or Fire Management Assistance.

- **Provide more flexibility to improve access in rural areas –** BCBSA strongly supports CMS' new proposals to provide flexibility in network adequacy requirements, especially in rural areas.

- **Assure adequate payments as MA plans prepare for an influx of End Stage Renal Disease (ESRD) beneficiaries–** BCBSA urges CMS to take necessary steps to prepare for 2021, including addressing MA ESRD payment inadequacy. We support CMS' proposals to provide more flexibilities to increase beneficiary access to dialysis as well as adjustment to the Maximum Out-of-Pocket (MOOP) calculation. However, we are concerned that if CMS does not address the inadequacy of MA ESRD benchmarks and expand access to value-based care options for ESRD patients, all MA beneficiaries could be negatively impacted through increased premiums, decreased benefits and fewer plan options.

- **Ensure dually eligible beneficiaries have access to the most appropriate plan –** BCBSA supports efforts to promote integration for beneficiaries eligible for both Medicare and Medicaid and recommends CMS implement any proposal regarding Dual Eligible Special Needs Plan (D-SNP) "look-alikes" in a way that minimizes beneficiary disruption and recognizes state requirements and market dynamics. Specifically, we recommend CMS delay this proposed policy by at least one year, to 2023, and suggest technical changes to ensure the policy is implemented appropriately and targeted to beneficiaries who do not otherwise have access to integrated plans.

Thank you for the opportunity to provide detailed comments and recommendations. We would be pleased to discuss our comments with you at your convenience. Questions regarding these comments may be directed to Sarah.Ravel@bcbsa.com.

Sincerely,

Kris Haltmeyer
Vice President, Legislative & Regulatory Policy
Office of Policy & Representation

DETAILED COMMENTS ON MEDICARE AND MEDICAID PROGRAMS; POLICY AND TECHNICAL CHANGES TO THE MEDICARE ADVANTAGE, MEDICARE PRESCRIPTION DRUG BENEFIT, PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE), MEDICAID FEE-FOR-SERVICE, AND MEDICAID MANAGED CARE PROGRAMS FOR YEARS 2020 AND 2021 (CMS-4185-P)

Section II: Implementation of Certain Provisions of the Bipartisan Budget Act of 2018

Special Supplemental Benefits for the Chronically Ill

Issue #1: Chronic Conditions Eligible for SSBCI

The Bipartisan Budget Act (BBA) of 2018 expanded the type of supplemental benefits that MA plans can offer to include "Special Supplemental Benefits for the Chronically Ill" (SSBCI). These benefits do not have to be primarily health related, and CMS is authorized to waive the uniformity requirements. In this rule, CMS proposes to codify existing guidance from previous Health Plan Management System (HPMS) memos and the 2020 MA and Part D Call Letter and allow plans additional flexibility to target enrollees with conditions beyond those on the Chronic Condition Special Needs Plans (C-SNP) list (outlined in the Medicare Managed Care Manual Chapter 16b).

Recommendation #1:

BCBSA appreciates CMS' implementation of provisions in the BBA that provide plans with more flexibility in their supplemental benefits and encourages CMS to finalize these provisions as proposed.

Rationale #1:

We agree with CMS that the definition of chronically ill in the Medicare Managed Care Manual may not reflect the full universe of beneficiaries who could benefit from SSBCI. This new flexibility will improve the ability of MA plans to target care and effectively manage their members.

Improvements to Care Management Requirements for Special Needs Plans (SNPs)

Issue #1: Implementation of BBA Requirements

The BBA of 2018 modified requirements for C-SNPs related to the interdisciplinary team, requirements for face-to-face encounters and the mandatory model of care (MOC), including its annual evaluation and approval. CMS proposes to implement these requirements and extend them to all SNP types.

Recommendation #1:

BCBSA opposes CMS' proposal to extend the C-SNP requirements enacted in the BBA to Dual Eligible Special Needs Plans (D-SNPs) and Institutional Special Needs Plans (I-SNPs).

Rationale #1:

D-SNPs and I-SNPs provide important, specialized care for high-risk beneficiaries, and these plan types already have significant requirements for care management. We believe extending the BBA requirements specifically designed for C-SNPs to these SNPs would be duplicative and unnecessarily burdensome.

Issue #2: Interdisciplinary Team in Management of Care

CMS proposes to require each MA organization offering a SNP to provide enrollees with an interdisciplinary care management team that includes a team of providers with demonstrated expertise and training and, as applicable, training in a defined role appropriate to their licensure in treating individuals similar to the targeted population of the plan.

CMS specifically requests feedback on how plans can meet the requirements for both demonstrated expertise and training in an applicable specialty.

Recommendation #2:

BCBSA believes there are existing requirements that ensure beneficiaries have access to providers with appropriate expertise and encourage interdisciplinary team management, therefore, additional requirements would be redundant. If CMS proceeds with this proposal, BCBSA recommends that CMS limit documentation requirements related to the composition of the care team and demonstration of expertise and training of providers.

Rationale #2:

BCBSA supports the intent of this provision and agrees with CMS that every enrollee in a C-SNP should have access to an interdisciplinary team in the management of their care. However, we believe existing requirements, such as network adequacy and quality measures, already ensure the expertise and training of providers on an interdisciplinary team and encourage care management.

Issue #3: Face-to-Face Annual Encounters

CMS proposes to require a “face-to-face” encounter between enrollees and a member of the enrollee’s interdisciplinary team or the plan’s case management and coordination staff on at least an annual basis, beginning with the first 12 months of enrollment, and “as feasible” with the individual’s consent. CMS proposes that this “face-to-face” encounter must be either in person or through a visual, real-time interactive telehealth encounter.

Recommendation #3:

BCBSA recommends that CMS expand this requirement to include a visit or encounter with any provider, which could include any provider involved in a beneficiary’s care, not only those on the interdisciplinary team. CMS should also provide additional information to plans about how they intend to measure this requirement, including how they plan to interpret the “as feasible” language. We also support the proposed flexibility that this requirement may be meet via telehealth.

Rationale #3:

Face-to-face encounters are an important part of care coordination, and CMS' policy should ensure it captures all the ways these plans interact with their beneficiaries.

Issue #4: Health Risk Assessments and the SNP Enrollees' Individualized Care Plan

As part of the C-SNP model of care, the results of the initial assessment and annual reassessment (required for each enrollee) must be addressed in the individualized care plan. CMS proposes to extend this requirement to the model of care for all SNPs.

Recommendation #4:

BCBSA supports this proposal. In general, BCBS Plan SNPs already implement this practice, and, therefore, we do not have concerns with the proposal. However, we want to emphasize that individual care plans are member-centric and allow beneficiaries to choose their own goals. As a result, not every issue identified in an assessment becomes part of the care plan. BCBSA encourages CMS to account for this by allowing for as much flexibility as possible and clarifying that the individual care plan is a collaborative document between the beneficiary and his/her care team.

Rationale #4:

A care plan is designed to prioritize a beneficiary's needs, identify the goals that are most important to them, and facilitate interventions where coordination and support might be lacking. As such, not every issue identified in an assessment becomes part of the care plan. For example, a Care Coordinator developing a care plan may see a need for assistance with household tasks, but the beneficiary may have a family member who comes over to help with those tasks and does not want outside assistance. This would not typically be identified as a goal within the care plan, but would be identified in the assessment.

If this requirement is implemented with little flexibility, the care plan is likely to become a less effective tool for patient engagement and care improvement.

Issue #5: SNP Fulfillment of the Previous Year's MOC Goals

CMS proposes, as part of the evaluation and approval of the SNP model of care, that the National Committee for Quality Assurance (NCQA) must evaluate whether goals were fulfilled from the previous model of care. Additionally, plans would need to provide relevant information pertaining to the MOC's goals as well as appropriate data pertaining to the fulfillment of the previous year's MOC's goals. If the SNP model of care did not fulfill the previous year's MOC's goals, the plan must indicate in the MOC submission how it will achieve or revise the goals for the plan's next MOC.

Recommendation #5:

BCBSA supports this proposal with modifications. We ask CMS to recognize that MOC goals are often multi-year and can reflect treating different individuals or populations over time (so

some goals become evergreen as new individuals are engaged). In these cases, plans should not be penalized for failing to meet all goals within a year.

In addition, we recommend that requirements related to fulfillment of MOC goals be distinct from goals for quality performance, which are separate standards for SNPs. If these requirements do overlap, then we suggest that compliance with quality goals would meet the requirements for MOC goals.

Rationale #5:

It is not uncommon for an MOC to include goals that are intended to be achieved across two or more years, and plans shouldn't be penalized for not meeting these goals in a single year.

Issue #6: Establishing a Minimum Benchmark for Each Element of the SNP MOC

Currently, the HHS Secretary establishes a minimum benchmark for each element of the C-SNP model of care, and the MOC can only be approved if each element meets a minimum benchmark. CMS proposes to implement these benchmarks for all SNP MOCs before they can be approved.

Each SNP model of care would be evaluated based on a minimum benchmark for four elements: description of the SNP population, care coordination, SNP provider network, and MOC quality measurement & performance improvement. Currently, each sub-factor of an MOC element is valued at zero to four points with the score of each element based on the number of factors met for that specific element; the aggregate total of all possible points across all elements equals 60, which is then converted to percentage scores based on the number of total points received. CMS proposes that each element of the MOC must meet a minimum benchmark of 50 percent of total points as allotted, and a plan's MOC would only be approved if each element of the model of care meets the applicable minimum benchmark.

Recommendation #6:

BCBSA recommends that CMS release more information to enable more complete recommendations. In the meantime, CMS should delay the implementation of this proposal until 2022 and consider a transition/trial year in which MOCs are scored under both the old and new system so that plans can fully evaluate the impact.

We also urge CMS to consider additional steps to improve consistency of auditor evaluations.

Rationale #6:

BCBSA believes it is difficult to provide a thorough response to this proposal without additional information, particularly about the impact of the 50 percent threshold. This change would increase the importance of the MOC evaluation and approval; therefore, it is critical for plans to be able to fully evaluate and comment on the impacts and for CMS to ensure that auditors use consistent and unbiased criteria in evaluating the MOCs.

We note that BCBS Plans have experienced significant variations across auditors and have even received different scores from different auditors on identical MOCs.

Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes

Issue #1: Proposals to Address D-SNP "Look-Alikes"

In the Proposed Rule, CMS expresses concerns with D-SNP "look-alikes," which are MA plans that are not SNPs, but have levels of dual eligible enrollment that are "virtually indistinguishable" from SNPs and exceed that of a typical MA plan. CMS proposes that beginning in plan year 2022, the agency will not enter into or renew a contract for a D-SNP look-alike in any state where there is a D-SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals.

Recommendation #1:

BCBSA supports CMS' efforts to encourage D-SNP integration and recognizes the concerns regarding D-SNP look-alikes. We encourage CMS to implement this proposal in a way that minimizes beneficiary disruption and is informed by the nuances of state D-SNP policies. Specifically, we encourage CMS to allow at least one additional year (beginning in 2023) to implement this policy.

Rationale #1:

BCBSA agrees that advancing integration for individuals dually eligible for Medicare and Medicaid is critically important. This involves a transparent process by which beneficiaries can select plans that best meet their needs. Allowing an additional year for implementation will minimize beneficiary disruption.

Issue #2: Enrollment Threshold to be a D-SNP "Look-Alike"

For the purposes of the policy described above, CMS proposes to not enter into or renew a contract for a D-SNP "look-alike" plan in any state where there is a D-SNP or other plan authorized by CMS to exclusively enroll dually eligible individuals. CMS will treat a plan as a D-SNP "look-alike" if the plan:

- Projects enrollment in its bid that 80 percent or more of its total enrollment are dual eligibles; or
- Has actual enrollment, as determined by CMS using the January enrollment of the current year, consisting of 80 percent or more of dual eligibles, unless the plan has been active for less than one year and has enrollment of 200 or fewer individuals.

Recommendation #2a:

BCBSA recommends that CMS clarify that the 80 percent dual threshold only applies to full-benefit duals rather than full and partial duals. CMS should also clarify what data source the agency will use to determine the percentage of duals in a plan.

Rationale #2a:

Benefit integration between Medicare and Medicaid is important for full benefit duals, who receive benefits under Medicaid and Medicare. While partial benefit duals also benefit from the care coordination provided by all MA plans (SNP and non-SNP), because they only receive premium and/or cost-sharing assistance from Medicaid, not benefits, they have less need for integration with Medicaid benefits. Given the potential disruption to a number of beneficiaries currently in high-performing D-SNP look-alike plans, keeping the threshold at 80 percent and applying it only to full-benefit duals will help ensure that a beneficiary's care is not negatively impacted, beneficiary choice remains and confusion is minimalized.

Recommendation #2b:

We support CMS' exception to this policy in states without a D-SNP or other plan authorized to exclusively enroll dually eligible individuals. However, we recommend that CMS narrow application of this proposed policy from the state to the county level.

Rationale #2b:

Beneficiary access to a D-SNP is at a county level, not a state level – the presence of a D-SNP in some counties within a state does not provide access to coordinated care for dually eligible beneficiaries living in other counties. Plans are aware of several instances where the state may allow for new D-SNPs, but the creation of a D-SNP is restricted at a market or county level.

Therefore, CMS should continue to allow look-alike plans to operate in counties without D-SNPs or other integrated plans.

Issue #3: <u>Timing of Notification</u>

CMS proposes to make the determination of whether an MA organization has a non-SNP MA plan with actual enrollment exceeding the established threshold for D-SNP look-alikes using the plan's enrollment in January of the current year. CMS intends to make these evaluations and issue the necessary information to affected MA organizations early in the coverage year. CMS believes this timing would allow MA organizations the opportunity to make an informed business decision to apply and contract for a new D-SNP, create a new MA plan, or terminate the D-SNP look-alike and not submit a bid for the following contract year.

Recommendation #3:

BCBSA recommends that CMS delay the initial implementation of this policy to contract year 2023, in order to give MA organizations sufficient time to develop new products or apply for a new plan, especially given state requirements for integrated plans. Plans should be notified of their status in early 2021, which provides sufficient time to ensure a smooth transition. The focus should be on beneficiary communications and transitions as needed.

We also recommend affected beneficiaries be directly provided the option to stay with a MA plan that would ensure continued integration of their Medicare and Medicaid benefits.

Rationale #3:

As plans work to enter into agreements with states and stand-up compliant, integrated D-SNP products to transition members into (so as to avoid disruption in care), we do not believe that the timing between the finalization of this rule and the 2022 proposed start date for this policy change will be sufficient in all instances.

Additionally, regarding CMS' proposal to accommodate beneficiaries in terminated look-alike plans, we encourage CMS to consider the implications of this policy where the beneficiary is enrolled in a Medicaid plan that is sponsored by the same organization as the D-SNP look-alike plan. We believe it would be detrimental to make that beneficiary have to choose coverage or be forced to also change their Medicaid carrier as a result of this policy. Such a disruption in ongoing care plans and care teams at the *individual level* is likely to outweigh any additional benefit from the D-SNP integration requirements at the *plan level*.

Section III: Implementation of Several Opioid Provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act

Mandatory Drug Management Programs (DMPs)

Issue #1: Support Act Implementation

The SUPPORT Act made changes to the requirements for Part D DMPs to enhance Part D sponsors' ability to reduce the abuse or misuse of opioids in their prescription drug benefit plans. CMS proposes two corresponding changes to the Part D DMP provisions codified in § 423.153(f):

1. Requiring Part D sponsors to adopt DMPs with respect to a plan year on or after Jan. 1, 2022, as required under section 2004 of the SUPPORT Act.
2. Requiring inclusion of Part D beneficiaries with a history of opioid-related overdose in sponsors' DMPs beginning Jan. 1, 2021.

CMS is also proposing to amend regulatory language to reflect the requirements that no later than 2022, Part D sponsors must have established DMPs.

Recommendation #1:

BCBSA supports CMS' proposal to require Part D sponsors to have established DMPs.

Rationale #1:

CMS' data shows that, since implementation of DMPs became an option in 2019, a large majority of plans (87.2 percent for calendar year 2020) have already adopted these programs to address opioid overutilization among their enrollees.

As CMS takes steps to make DMPs mandatory in 2022, BCBSA requests that the agency provide consistent guidance, particularly around the identification of potentially at-risk

beneficiaries and consistent lookback periods and exemption criteria for beneficiaries receiving long-term or end-of-life care.

Recommendation #1b:

BCBSA recommends that CMS add central nervous system depressants, such as gabapentin, to its list of "frequently abused drugs" so that plans are able to better manage the health and risk of beneficiaries taking them through Part DMPs.

Rationale #1b:

Gabapentin and other central nervous system (CNS) depressants have an elevated risk of abuse, particularly when take concurrently with opioids. Further, the FDA recently warned that abuse of that combination of therapies can lead to death in some cases.[1] Given that, we would like to recommend that CMS consider adding central nervous system depressants to its list of "frequently abused drugs."

We recognize there are potential challenges to this addition, namely that gabapentin and other CNS depressants are not federally controlled substances, one of the criteria for consideration for whether a drug should be included in the DMP, and that gabapentin falls under the list of protected class drugs in Part D. However, there is sufficient evidence to indicate the potential dangers of these drugs under the other two criteria defining a "frequently abused drug" is enough for CMS to consider adding them to the program. Additionally, gabapentin's protected class designation does not appear to interfere with its inclusion, as the management techniques used under the DMP are not intended to encourage beneficiaries to utilize a different product, but instead to ensure their safety and prevent drug abuse and diversion.

Beneficiaries with History of Opioid-Related Overdose Included in Drug Management

Issue #1: <u>Definition of Potential At-Risk Beneficiary</u>

Under section 2006 of the SUPPORT Act, CMS is required to identify Part D beneficiaries with a history of an opioid-related overdose (as defined by the HHS Secretary), and such individuals must be included as potential at-risk beneficiaries (PARBs) for prescription drug abuse under a Part D plan's DMP. In line with this requirement, CMS is proposing to modify the definition of "potential at-risk beneficiary" to include a Part D-eligible individual who is identified as having a history of an opioid-related overdose.

CMS proposes to define a beneficiary with a "history of opioid-related overdose" where a recent claim has been submitted that documents a beneficiary had a principal diagnosis code reflecting an opioid overdose, regardless of the type of opioid, and at least one recently submitted prescription drug event (PDE) for an opioid dispensed to such beneficiary.

[1] "FDA requires new warnings for gabapentinoids about risk of respiratory depression." December 2019. https://www.fda.gov/news-events/fda-brief/fda-brief-fda-requires-new-warnings-gabapentinoids-about-risk-respiratory-depression

CMS proposes to operationalize this proposed definition by using:

1. Diagnoses that include both Part D covered prescriptions and illicit opioid overdoses
2. A12-month lookback period from the end of each Overutilization Management System (OMS) reporting quarter, for record of opioid-related overdose within Medicare fee-for service (FFS) claims and Medicare Advantage Encounter data (excluding those not enrolled in a Part D plan, whether an MA-PD or stand-alone Part D plan (PDP))
3. A six-month lookback period from the end of each OMS reporting quarter, for record of a recent Part D opioid PDE

Recommendation #1:

BCBSA appreciates the intent to modify the definition of "potential at-risk beneficiary" to include a Part D-eligible individual who is identified as having a history of an opioid-related overdose. However, Plans have serious concerns about the feasibility of operationalizing this proposed definition and request that CMS postpones implementation until further details are provided.

Plans are especially concerned about the ability of stand-alone PDPs to identify members based on FFS data. For example, while stand-alone PDPs now have the ability to request a standardized extract of FFS claims data, it is unclear if the timing and contents of this data will be sufficient for these purposes.

BCBSA also seeks additional clarification on CMS' expectations for reviewing the cases of beneficiaries under this classification, as well as additional guidance on aligned exemptions, timeframes and qualifying criteria if such reviews are implemented as a requirement.

Rationale #1:

Stand-alone PDPs have the ability to request standardized extracts of FFS Medicare claims data on their members. However, this process is optional, and there is a significant time lag in the data.

Clarification on CMS' expectations for reviewing beneficiaries' cases is needed because beneficiaries with an overdose history should be regularly reviewed, and such a review is part of most plans' ongoing efforts. As such, including these reviews in the DMP process could be duplicative.

Information on the Safe Disposal of Prescription Drugs

Issue #1: <u>Information Provided During In-Home Health Risk Assessments</u>

MA plans are required to provide information on the safe disposal of prescription drugs when furnishing an in-home health risk assessment. CMS proposes to revise regulations to add a provision requiring MA plans that furnish an in-home health risk assessment on or after Jan.1, 2021, to include both verbal (when possible) and written information on the safe disposal of prescription drugs that are controlled substances in such assessments. CMS proposes specific information that must be included, such as information on drug takeback programs, safe in-

home disposal methods, and a web link to HHS' website identifying methods for the safe disposal of drugs.

Recommendation #1:

BCBSA requests that CMS provide additional clarity about what must be included in the health risk assessment to be complaint with this requirement. We recommend CMS provide sample language that plans can use. This sample language should contain information that recommends beneficiaries remove or conceal personal information prior to disposal. Additionally, we request CMS provide in the model language, or allow MA plans to provide, links to state and/or national websites that list current takeback sites, rather than requiring plans to include information on the hours and locations of takeback sites, which change frequently.

CMS should also consider alternate mechanisms for beneficiaries to receive this information, such as in their evidence of coverage (EOC) document, their annual notice of changes (ANOC) and/or a section in their version of the Medicare and You handbook. BCBSA also recommends CMS require the same notices to be communicated to FFS Medicare beneficiaries by prescribers and pharmacies.

Rationale #1:

BCBSA agrees with CMS on the importance of informing beneficiaries about safe disposal of prescription drugs, especially opioids. We believe that providing model language will assist plans with compliance with this requirement. Additionally, requiring prescribers and pharmacies to provide similar information will increase opportunities to inform beneficiaries about safe disposal of opioids.

Beneficiaries' Education on Opioid Risks and Alternative Treatments

Issue #1: <u>Information Provided to Beneficiaries</u>

Currently, all Part D sponsors disclose certain information about the risks of prolonged opioid use to all enrollees. In addition to this information, with respect to the treatment of pain, MA-PD sponsors must disclose coverage of non-pharmacological therapies, devices, and non-opioid medications under their plans. CMS proposes to amend requirements for Part D sponsors to disclose opioid risks and alternative treatment options to only a subset of plan enrollees, such as enrollees who have been prescribed an opioid in the previous two-year period, rather than disclosing the information to each plan enrollee.

Recommendation/Rationale #1:

BCBSA supports this proposal and appreciates the flexibility on how to identify the appropriate enrollees. We request that CMS provide more specific guidance on the information plans will be required to provide to each enrollee annually.

Eligibility for Medication Therapy Management Programs (MTMPs)

Issue #1: <u>Eligibility for MTM Programs</u>

CMS proposes to amend Part D Medication Therapy Management Program (MTMP) requirements to conform to the relevant SUPPORT Act provisions by expanding the population of beneficiaries targeted for MTMP enrollment ("targeted beneficiaries") to include at-risk beneficiaries (ARBs), and by adding a new service component requirement for all targeted beneficiaries. Under this proposal, Part D sponsors would be required to automatically enroll all at-risk beneficiaries in their MTMPs on an opt-out only basis. In addition, Part D sponsors would be required to offer each at-risk beneficiary to be enrolled in the MTMP the same minimum level of MTM services that sponsors currently are required for beneficiaries enrolled in their current MTMP. This means, in addition to interventions for both beneficiaries and prescribers, sponsors must offer ARBs an annual comprehensive medication review (CMR). The CMR must include an interactive, person-to-person, or telehealth consultation performed by a pharmacist or other qualified provider.

Recommendation #1:

BCBSA recognizes that this expansion in targeted enrollment for MTMPs is required by the SUPPORT Act. However, we are concerned about the impact of these expanded new enrollments in Part D MTMPs. BCBSA recommends CMS not wholly import all ARBs into MTMPs, but rather enable plans to incorporate ARB status as a factor (in conjunction with other criteria) to better target MTMPs.

Rationale #1:

BCBSA is concerned the expanded enrollment could overwhelm current MTMP resources, require additional administrative complexity, and potentially lead to beneficiary confusion.

MTMPs provide demonstrated value to beneficiaries who have multiple chronic conditions, are on multiple medications, and are expected to incur high prescription drug costs for the year. While at-risk beneficiaries may benefit from some MTMP elements (many already qualify under existing criteria), many beneficiaries are distinctly different from the current MTMP population.

The bifurcation of the MTMPs into two targeted groups of enrollees would have negative effects on plans, initially requiring them to make substantial updates to support readiness for Jan. 1, 2021, as current system logic and processes do not incorporate the ARB population into MTMP activities. Plans would also need immediate guidance to address any changes to MA bids. Finally, BCBSA is concerned that the addition of ARBs into the MTMP population will have unknown performance impact on the MTMP Completion Rate for CMRs Star Ratings measure. If CMS moves ahead with this proposal, the agency should proactively implement safeguards in the scoring of this measure in order to ensure that plans with a high population of ARBs are not adversely and unintentionally affected.

Issue #2: <u>Information about the Safe Disposal of Drugs</u>

Section 6103 of the SUPPORT Act added a new requirement that Part D sponsors provide beneficiaries enrolled in their MTMP with information about the safe disposal of prescription drugs that are controlled substances, including information on drug takeback programs, in-home disposal and cost-effective means for safe disposal of such drugs. To implement this new requirement, CMS proposes that Part D sponsors would be required to provide this information

to all beneficiaries enrolled in their MTMPs at least annually, as part of the CMR or through the quarterly targeted medication reviews (TMR), or follow-up.

Like MA plans, Part D plans would retain the flexibility to refine their educational materials based on updated information and/or on beneficiary feedback, so long as the materials meet the proposed criteria. Part D plans would have the discretion to furnish safe disposal information to the beneficiary during the CMR, a TMR, or another follow up service, depending upon the circumstances, as long as the required information is shared with each MTMP enrollee at least once per year.

Recommendation/Rationale #2:

BCBSA supports this proposal and appreciates the continued flexibility from CMS.

Automatic Escalation to External Review under a Medicare Part D Drug Management Program (DMP) for At-Risk Beneficiaries

Issue #1: Automatic Escalation to External Review

Under existing Part D appeals procedures, there is no automatic escalation to external review for adverse appeal decisions; instead, the enrollee (or prescriber, on behalf of the enrollee) must request review by the Part D independent outside review entity (IRE). Under the existing process, cases are auto-forwarded to the IRE only when the plan fails to issue a coverage determination within the applicable timeframe. While the HHS Secretary has discretion under statute to provide for automatic escalation of drug management program appeals to external review, CMS declined to exercise that discretion in previous rule-making.

Section 2007 of the SUPPORT Act requires that, if on reconsideration a Part D sponsor affirms its denial of a DMP appeal, in whole or in part, the case shall be automatically forwarded to the IRE. CMS proposes rules to codify this provision.

Recommendation #1:

BCBSA recommends modifications to the timeframes that would be required to meet this standard. We request that CMS continue to allow 72 hours for review of new information, then after the 72-hour timeframe, additional time to forward to the IRE. In addition, we disagree that providing the appeal notification on the first notice adds value to the beneficiary, since the first notice has a 30-day window to gain additional information, if necessary, before a final decision is made to implement a lock-in or POS edits. BCBSA recommends that appeal language is included only on second notices.

Rationale #1:

BCBSA is concerned that the proposed timeframes are operationally problematic and place an unnecessary burden on plans.

Section IV: Implementation of Certain Provisions of the 21st Century Cures Act

MA Plan Options for End-Stage Renal Disease (ESRD) Beneficiaries

Issue #1: Plan Options for ESRD Beneficiaries

CMS proposes to implement changes in the 21st Century Cures Act, which remove the prohibition for beneficiaries with ESRD from enrolling in an MA plan, effective for plan years on or after Jan. 1, 2021.

On the recent CMS stakeholder call, CMS stated that there are currently 131,000 beneficiaries in MA in 2020 with ESRD, and CMS is projecting roughly 83,000 additional beneficiaries with ESRD will enroll in MA over the next five years, with half in the first year (2021). On the Advance Notice stakeholder call, CMS discussed that they used plan and academic studies to develop these estimates.

Recommendation #1:

As discussed in detail in our comment letter on the 2021 MA and Part D Advance Notice (submitted to CMS on March 6, 2020), BCBSA recommends that CMS take necessary steps to ensure effective implementation of the provisions in the 21st Century Cures Act impacting MA plans as to this new enrollment. CMS should update MA ESRD benchmarks to more accurately reflect the actual costs of ESRD patients. It is critically important that CMS consider steps to improve ESRD payment adequacy, both related to benchmark calculations and ESRD risk adjustment, particularly as we look to 2021, and full integration of ESRD individuals into MA.

Specifically, we recommend:

- ESRD benchmarks: BCBSA continues to urge CMS to revise the current ESRD payment methodology, including exploring recommendations BCBSA offered in our issue paper, such as updating the ESRD ratebook methodology, carving out the dialysis bundle from MA ESRD payment, or anchoring ESRD payment within the MA ESRD ratebook methodology. We look forward to continuing to work with CMS to address these concerns.

- ESRD Growth Rate: To improve accuracy of the dialysis-only ESRD growth rate (United States per capita cost (USPCC)) and better align with the non-ESRD FFS USPCC, we encourage CMS to modify the methodology for the ESRD growth percentage to use five years of FFS claims data, rather than just one year. Such a change would more closely align the methodologies for the FFS and ESRD growth percentages and would reduce volatility in ESRD payment rates, which is critical as more ESRD beneficiaries are able to join MA in 2021. Additionally, in line with the non-ESRD FFS USPCC, BCBSA requests that CMS release more data and be more transparent about the specific data and trends, underlying methodology and other variables impacting growth updates. We appreciate inclusion of the dialysis-only ESRD USPCC in this year's 2021 Early Preview.

- Automatically move ESRD enrollees: In an effort to support the probable increase in ESRD MA enrollment levels, we ask CMS to move enrollees with a current chronic dialysis diagnosis into the MA ESRD payment and risk adjustment segment

automatically. The current process requires an extensive documentation process that adds significant administrative burden to members, providers and health plans. We request that CMS track ESRD enrollment during the open enrollment period (OEP) and pay MA plans the ESRD reimbursement amounts as of the first month of these new enrollments.

Rationale #1:

The MA program will see an influx of new ESRD patients in 2021, and CMS should take steps to assure that inadequate payments do not create new financial risks for plans, especially smaller plans. The payment methodology must account for the intersection of dialysis provider concentration and network adequacy requirements, which can undermine the ability for plans to negotiate reasonable reimbursement rates for dialysis services. This, among other factors, can mean that ESRD rates are not adequate to pay for the true costs of caring for these complex, high-cost patients. Inadequate payment for complex patients negatively impacts beneficiary care and inhibits the ability of plans to improve care coordination, reduce cost and innovate ways to improve beneficiary outcomes. By not addressing the chronic shortfall in revenue for ESRD members through a material increase in state benchmark calculations, CMS is creating the possibility of plans reducing benefits for all of their MA beneficiaries as well as raising the maximum out of pocket and inpatient (IP) benefit limits. When Congress moved to open up MA plans for ESRD members, they did not address payment issues and the fact that an influx of new ESRD members could have a significant impact on a plan's existing membership by raising their cost-sharing amounts and/or lowering their supplemental benefits, such as cost-sharing reductions, in order to achieve financial stability.

Though some variation is expected in growth rates year to year, we have concerns with how volatile the dialysis-only ESRD estimates have been, which make it difficult for Plans to model revenues and prepare bids. For example, the final update for 2021 was 9.81 percent, and the final update for 2020 was -0.48 percent. Currently, the ESRD growth percentage is developed based on the most recent calendar year of data available, trended to the upcoming year, leading to large swings and volatility in ESRD payment. The FFS growth percentage is developed based on the most recently available five years of data repriced based on the upcoming year's Medicare fee schedule, which provides more data to facilitate more consistent rates year over year.

In addition, consistent with the Administration's Advancing American Kidney Health initiative, CMS should provide MAOs with the option of participating in the CMMI kidney models to improve the dissemination of best practices in kidney care. With a focus on care coordination and whole-person health, BCBS Plans are well-positioned to participate in, and achieve the goals of, improving chronic kidney disease management, lowering the incidents of patients progressing to ESRD, increasing ESRD home care, and increasing kidney transplant opportunities through value-based payment arrangements.

Medicare Fee-for-Service (FFS) Coverage of Costs for Kidney Acquisitions for MA Beneficiaries

Issue #1: <u>Coverage of Costs for Kidney Acquisitions</u>

CMS proposes to implement changes made by the 21st Century Cures Act, which exclude organ acquisitions for kidney transplants from the list of items or services an MA plan is required to cover and, instead, mandates that these costs will be covered under FFS.

Recommendation/Rationale #1:

BCBSA supports this change and provides comments below.

Exclusion of Kidney Acquisition Costs from MA Benchmarks

Issue #1: Calculation of MA Benchmarks

Starting in 2021, the 21st Century Cures Act directs CMS to exclude kidney acquisition costs, which are the standardized costs for payments for organ acquisitions for kidney transplants, from the FFS county benchmarks. Therefore, starting in 2021 the specified amount, which is the benchmark using the post-ACA formula, is as follows: Specified amount = (2021 FFS cost minus (IME phase-out amount + kidney acquisition costs)) × (applicable percentage + applicable percentage quality increase). CMS released 2021 Preliminary Kidney Acquisition Cost Carve-out Factors and Applicable percentages.

CMS laid out a nine-step process to comply with Section 17006(b) of the 21st Century Cures Act, which directs CMS to exclude the agency's estimate of the standardized cost elements for payments for organ acquisition for kidney transplants from MA benchmarks starting in 2021. CMS states the impact of excluding kidney acquisition costs will vary by county, with a FFS enrollment-weighted average impact of approximately $4 PMPM for the MA (i.e., non-PACE) non-ESRD county rates and a FFS enrollment-weighted average impact of about $36 PMPM for the MA (i.e., non-PACE) ESRD state rates. For the 2021 MA (i.e., non-PACE) county rates, the largest impact is estimated to be about $20 PMPM, and for the 2021 MA (i.e., non-PACE) ESRD state rates, the largest impact is estimated to be about $75 PMPM. CMS is releasing the preliminary 2021 kidney acquisition cost carve-out factors for MA plans by county and state.

Recommendation #1:

BCBSA wants to ensure the kidney acquisition costs accurately reflect the true costs for organ acquisitions for kidney transplants to ensure CMS is not reducing the benchmarks inappropriately. To this end, we recommend the following:

- Counties with transplant centers: BCBSA has concerns that the calculation disadvantages counties with a transplant center in or near them, and we recommend adjusting accordingly. It appears CMS is assuming that within a transplant facility, the percentage of kidney transplant discharges of total discharges by patient or county is equal. However, counties farther from the transplant center may have a larger percentage of kidney transplant discharges since beneficiaries not receiving transplants may be utilizing hospitals closer to their residence. This assumption has the unintended negative consequence of allocating higher or excessive costs to the counties that have transplant centers.

- Acquisition cases by provider: We suggest that CMS explore using the number of acquisition cases by provider and county rather than allocating using the total patient cases by county to produce a more reasonable allocation.

- Phase-in: We suggest that CMS consider phasing in the kidney acquisition cost benchmark adjustment similar to how the agency phased in the graduate medical education (GME) and indirect medical education (IME) adjustments.

- Consider MAO experience data: We ask that CMS consider MAOs' data and actual experience with kidney acquisition costs, which Plans estimate to vary by state and are substantially lower than $4 PMPM. This may be influenced by our interpretation of CMS' calculation of these costs, which reinforces the need for specific detail and further guidance in this area. The discrepancy may also reflect the volatility of the costs of care for this patient population. Because CMS' FFS data includes a greater proportion of kidney transplant patients compared to individual MAOs, we are concerned about the disproportionate impact the $4 PMPM reduction in benchmarks will have with minimal or no claims reductions to offset this revenue loss. CMS' consideration of specific MA data and experience, and disclosure of key methodological steps the agency used to develop the proposed benchmark reduction, will help ensure the accurate and appropriate exclusion of kidney acquisition costs from the benchmark.

- Release CMS data elements included in the carve out and other data: We request that CMS release more data to support its 2021 Preliminary Kidney Acquisition Cost Carve-out Factors and Applicable percentages, including all the elements included in the carve out and underlying data. In particular, it would be helpful if CMS could identify the specific donor, provider and hospital services included in the kidney acquisition costs obtained from the cost reports (e.g. donor surgery, the cost of the kidney itself, travel expenses, etc.) and provide a quantitative example of the calculation discussed in Step 5. The regulatory impact section of the recently Proposed Rule, "Policy and Technical Changes to the Medicare Advantage and Part D Programs for CY 2021," states that the costs for these services are expected to be lower than the amount that is expected to be excluded from the MA benchmarks.

Rationale #1:

BCBSA has concerns that the preliminary adjustments proposed by CMS are excessive and do not reflect current kidney acquisition costs in MA. If CMS excludes costs that are artificially high, it will exacerbate the current issues of underpayment in MA for ESRD.

Section V: Enhancements to the Part C and D Programs

Reinsurance Exceptions

Issue #1: Reinsurance Exceptions

In general, MA organizations are required to assume full financial risk for the provision of basic benefits furnished to enrollees. However an exception at section 1855(b)(1) allows MA

organizations to obtain reinsurance above a per-enrollee aggregate level established by the Secretary.

CMS proposes to implement the statutory exception in regulation because of concerns that there was legal uncertainty regarding the permitted use of reinsurance in the MA program. CMS proposes that an MA organization may obtain reinsurance or make other arrangements for the cost of providing basic benefits if the aggregate value of such an arrangement exceeds a $10,000 aggregate per individual (or the first-dollar equivalent).

Recommendation #1:

BCBSA appreciates CMS' concern that overly generous reinsurance could lead to moral hazard. However, we believe the Proposed Rule does not accommodate the different uses of reinsurance or explicitly grant exceptions where the reinsurer and MAO are owned by a common parent. We, instead, recommend a minimum standard of 10 percent risk assumption where the MAO obtains reinsurance from an affiliate and/or a joint venture or alliance partner.

We also appreciate the flexibility CMS is extending by not requiring plans to purchase reinsurance and, instead, leaving the choice up to the plans.

Rationale #1:

While BCBSA appreciates CMS' desire to balance risk-assumption with potential moral hazards, we would like to make the Administration aware of situations where reinsurance is used for the purpose of allocating risk among participants in an MA venture or alliance. For example, a local plan may wish to pair its market knowledge with the operational expertise of a larger player. The two organizations take on the joint responsibility to administer the product and use a reinsurance agreement as a mechanism to allocate the proportional profits/losses of the venture or alliance – related to the stake in the venture or alliance.

These types of arrangements can lead to better products for members that are fiscally sound, higher-quality, have lower administrative costs, and are more tailored to local demands than either participant could do independently. To this end, we believe CMS' proposal is overly broad in its application to reinsurance and would have unintended consequences by eliminating arrangements designed as profit-share distribution mechanisms between participants in the venture or alliance.

In order to accommodate the multiple uses of reinsurance in the business of MA, we propose adopting an alternative standard: An MA organization may obtain insurance, reinsurance or make other arrangements for the cost of providing basic benefits to an individual enrollee that either the aggregate value of which exceeds an aggregate level that is greater than or equal to $10,000 during a contract year or through quota share reinsurance on a first dollar proportional basis, where the MA organization or an affiliate of the MA organization retains a minimum 10 percent quota share percentage of the risks being transferred.

We urge CMS to make accommodations in its Proposed Rule for situations where an MAO obtains reinsurance from an affiliate and/or a joint venture or alliance partner. As noted earlier, because reinsurance is a useful means by which to share profits/losses in joint ventures and

alliances, an entity may choose to allocate its risk to a reinsurer that is an affiliate of the MAO and to another joint venture or alliance partner. Again, such arrangements are not about the abdication of risk, but rather serve as a mechanism to facilitate the allocation of profits/losses under a joint venture or alliance.

Issue #2: Definition of Parent Company

CMS is also proposing to broaden its interpretation of MA organization for purposes of this statute to include the MA parent organization.

Recommendation #2:

BCBSA supports evaluation of compliance with section 1855(b) at the parent organization level. CMS should consider a parent organization to be part of an MA organization for purposes of section 1855(b) of the Act.

Rationale #2:

Reinsurance between wholly-owned subsidiaries and the parent organization is a common and long standing market practice for both commercial health insurers and MA organizations, and the practice serves to reduce financial exposure to changes in healthcare costs, helps effectively manage capital requirements, and allows healthcare insurers to grow enrollment, particularly in rural underserved counties.

Out-of-Network Telehealth at Plan Option

Issue #1: Out-of-Network Telehealth

The BBA of 2018 authorized MA plans to offer additional telehealth benefits (ATBs) to enrollees starting in plan year 2020 and to treat ATBs as basic benefits. In rule-making last year, CMS finalized a requirement that MA plans furnishing ATBs only do so using contracted providers – any benefits furnished by a non-contracted provider through electronic exchange could only be covered by an MA plan as a supplemental benefit.

At the time, CMS believed this limitation on providers was needed to ensure oversight of providers' performance. CMS is now considering whether this requirement unnecessarily limits the ability of MA plans to offer ATBs. Therefore, CMS is considering whether to revise §422.135 to permit ATBs to be provided by non-contracted providers in cases whether the non-contracted providers satisfy ATB requirements set forth in the April 2019 Final Rule.

Recommendation #1:

BCBSA supports this proposal, which will help increase access to telehealth for beneficiaries

Rationale #1:

This proposal will give plans more flexibility to offer additional telehealth benefits and help accelerate the growth of telehealth to improve beneficiary choice and access to care.

Referral/Finder's Fees

Issue #1: Referral/Finder's Fees

Under existing rules regarding agent and broker compensation, compensation for initial enrollments is limited to Fair Market Value (FMV), and compensation for renewal enrollments is limited to 50 percent of fair market value. CMS does not believe the limits on referral fees are necessary, since total compensation, of which referral fees are a component, are also subject to limits. Therefore, CMS proposes to eliminate the current specific limit on finder or referral fees codified in regulation.

Recommendation #1:

BCBSA views referrals and enrollment as different activities, and, thus, we recommend CMS consider payment for these activities separately. Therefore, instead of bundling referral fees within the definition of FMV, we propose the agency allow for reasonable referral and enrollment fees separate and apart from FMV.

Rationale #1:

CMS seeks to clarify that compensation is on a per-enrollment basis. Since referral fees are part of compensation, organizations may not pay independent agents more than regulatory limits. Because referral fees are already incorporated into compensation, CMS believes limiting the amount of a referral fee has no impact on the statutory requirement of an agent enrolling a beneficiary in the plan that best meets their healthcare needs. However, in some Plans' experience the referring agent is often different than the agent or broker who enrolls the beneficiary. Therefore, we request the ability to handle the referral and enrollment fees separately.

MA and Part D Prescription Drug Program Quality Rating System

Issue #1: Overarching Recommendations to Improve the Stars Rating Program

Recommendation/Rationale #1:
BCBSA would like to offer several recommendations to improve the reliability and effectiveness of the MA and Part D Quality Star Ratings System. Specifically, we request that CMS:

- Restore prospective cut points and more transparency. Although we appreciate the great strides CMS has made in providing more transparency in the federal rule-making process with required notice and comment on the Star Ratings, BCBSA strongly recommends that CMS restore the process of making the measure cut points prospective for both Parts C and D measures. This change is needed to better support the ability of plans and providers to engage in value-based contracts that incentivize higher quality. Additionally, CMS should provide comprehensive analysis regarding the cut-point guardrails in place for non-CAHPs measures beginning for 2022 Star Ratings, and CMS should consider a cap of less than 5 percent.

- Only apply the Categorical Adjustment Index (CAI) if it positively impacts a plan's ratings. BCBSA has supported CMS' continued efforts to address the impact of socio-

economic and disability status on Stars ratings and appreciates CMS' attention to stakeholder feedback on this issue. However, in our experience, the CAI is insufficient to address this important problem and we look forward to working with CMS to reach a long-term solution.

- Create, publicize and follow a set of methodological criteria that specify minimum levels of reliability for all measures, including, but not limited to, the health outcomes survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. Adopting and abiding by such minimum reliability thresholds at the measure-contract level (since reliabilities can vary across contracts, even for the same measure) would clarify CMS' intent in implementing the Star Ratings program, set lower bounds on the degree of arbitrariness in distributing financial rewards and penalties, and help CMS and its contractors proactively identify and avoid any future inclusion of measures with unacceptably low reliabilities in the Star Ratings program.

Issue #2: Definition of New MA Plan

CMS proposes to amend and clarify the definition of a "new MA plan." Currently, a "new MA plan" is defined as an MA contract offered by a parent organization that has not had another MA contract in the previous three years. CMS proposes to modify this definition and, instead, define a "new MA plan" that is:

1) Offered under a new MA contract
2) Offered under an MA contract that is held by a parent organization that has not had an MA contract in the prior three years

Recommendation/Rationale #2:

BCBSA supports this change and appreciates clarity on this issue.

Issue #3: Methodology for Removal of Outliers

In previous rule-making, CMS has considered options for removal of outliers in the methodology to calculate Stars scores for non-CAHPs measures, but did not finalize an approach. In this Proposed Rule, CMS discusses two options to address the direct removal of outliers and proposes to apply the Tukey outlier fence deletion methodology, rather than a trimming methodology.

CMS believes that the Tukey outlier fence deletion is preferable to the alternative because trimming would remove all scores below the 1st percentile or above the 99th percentile, which could delete scores that are not true outliers and retain scores that are outliers.

CMS estimates that this change alone would reduce plan payments by over $800 million in 2024 and up to $1.4 billion in 2030. Combined with other proposals and accounting for the impact of ordinary inflation, CMS estimates a net reduction of nearly $5 billion over 10 years.

Recommendation #3:

BCBSA is concerned that this outlier methodology would dramatically decrease payments to plans by reducing Star Ratings for most plans. CMS should not finalize this proposal and should consider other policies to remove outliers that would not have such a dramatic impact on plan payments.

Furthermore, it is difficult for plans to evaluate these proposals without full information about the impact of the proposal on their plan-specific Stars Ratings. BCBSA recommends that CMS consider publishing a display version of cut points with and without the proposed outlier deletion so that plans can fully evaluate the impact.

Rationale #3:

CMS estimates that if the Tukey fence outlier deletion and a five percent guardrail had been implemented for the 2018 Star Ratings, 2 percent of MA-PD contracts would have seen their Star Ratings increase by half a Star, while 16 percent would have decreased by half a Star and one contract would be reduced by a full Star. For PDP contracts, 2 percent would have increased by half a Star and 18 percent would have decreased by half a Star.

These large decreases go beyond the scope of a policy aiming to address outliers, especially when Plan-specific impacts are difficult to analyze and prepare for. To ensure stability in the Stars system, CMS should not finalize the policy as proposed and work with stakeholders to develop a less disruptive policy that addresses outliers.

Issue #4: Contract Consolidations

CMS proposes several changes to regulations on how contract consolidations are treated in calculating Star Ratings. CMS proposes two new policies effective for contract consolidations approved on or after Jan. 1, 2021:

- In cases where a measure score is missing from the consumed or surviving contract(s) due to a data integrity issue, CMS proposes to assign a score of zero for the missing measure score in the calculation of the enrollment-weighted measure score.
- For appeals measures, CMS proposes to combine the Timeliness Monitoring Project (TMP) or audit data for the consumed and surviving contracts before applying their existing methodology for reducing a contract's measure for IRE data.

Recommendation #4:

BCBSA supports this proposal**.**

Rationale #4:

We agree that this will help to clarify the issue of assigning Stars to consolidated contracts.

Issue #5: Proposed Measure Removal

CMS proposes to remove the Rheumatoid Arthritis Management measure from the Part C Star Ratings for the 2021 measurement year and the 2023 Star Ratings since NCQA is retiring this measure.

Recommendation #5:

BCBSA agrees with this proposal.

Rationale #5:

We agree with CMS' rationale for removing this measure from Part C Star Ratings.

Issue #6: <u>Proposed Measure Updates: HOS Measures</u>

CMS proposes two changes to the Improving or Maintaining Physical Health (PCS) Measure and Improving or Maintaining Mental Health (MCS) Measure from the HOS.

First, CMS proposes to change the way the case-mix adjustment address missing variables. Currently, if any of the case-mix variables in a group are missing for a beneficiary, none of the variables in the group are used. CMS proposes to replace this "all-or-nothing" approach with one in which they replace a missing adjuster with the mean value for that adjuster for other beneficiaries in the same contract.

Second, CMS proposes to increase the minimum required denominator from 30 to 100 for the two measures. The proposed increase to the minimum denominator would bring these measures into alignment with the denominator requirements for the HEDIS measures that come from the HOS survey and increase the reliability for these measures compared to the current reporting threshold of 30**.**

Recommendation #6a:

We applaud CMS' decision in the recently released Interim Final Rule to postpone until late summer (and maybe later) this year's HOS survey, administered by NCQA in partnership with CMS, which was scheduled to be from April through July 2020. This survey administration has been postponed to late summer, and CMS will continue to monitor the situation to see if any further adjustments are needed.

Rationale #6a:

It is appropriate to reduce burden while the healthcare system rises to face the COVID-19 pandemic. Additionally, beneficiaries should not be asked to complete surveys at a time when they are facing this crisis.

Recommendation #6b:

Moving forward beyond this pandemic, BCBSA appreciates the changes CMS proposes to improve the comparability and reliability of the Improving or Maintaining Physical and Mental Health measures, but we do not believe these adjustments go far enough to address our concerns about the reliability and validity of these measures. We do not believe the Improving or Maintaining Physical Health and Improving or Maintaining Mental Health measures should

continue to be part of the Star Ratings unless modifications produce year-over-year consistency and reliability.

Rationale #6b:

BCBSA would like to reiterate our comments from the 2021 Advance Notice, in which we expressed concerns about the reliability of measures derived from the HOS instrument in differentiating quality performance across MAOs is low. BCBSA has shared with CMS our summary of the findings of a 2017 RAND research report as well as an internal analysis conducted with five years (2015-2019) of HOS performance scores, which found that there was significant volatility year-over-year in MAOs' HOS performance. As a result of these findings, and in conjunction with the other BCBS Plans, we request CMS: (1) conduct an independent study to confirm and address reliability and validity concerns; (2) define standards for reliability and publish the reliability for all Star measures in line with or exceeding the National Quality Forum standards; and (3) work with stakeholders to determine the best ways to measure outcomes and how plans can influence them.

Recommendation #6c:

BCBSA generally supports the proposed changes to case mix adjustments but requests that CMS publish reliability data under the old case mix methodology and new case mix methodology.

Rationale #6c:

In the 2019 Final Rule CMS set out guiding principles used in making enhancements and updates to Star Ratings. One of these principles is that "data are complete, accurate, and reliable."

Multiple studies validate the reliability of the core components of the two current Outcomes Measures (VR-12 PCS and MCS). However, there is less research on the Performance Measures used in the Stars Program (Improving or Maintaining Physical Health, and Improving or Maintaining Mental Health). One such study[2] (focused on individuals with chronic conditions) was conducted by RAND, and its conclusion was that the VR-12 PCS and the VR-12 MCS "point-in-time" measures are reliable, but the measures used to gauge change in those components over time have very low reliability. While the study's focus was not on the entire beneficiary population, its conclusions are still concerning, and indicates possible reliability concerns with the two Star Outcomes Measures. We request that CMS publish the reliability of the outcomes measures to respond to this concern.

Our concern for reliability is rooted in trends we have observed in industrywide performance in the two Outcomes measures. Data indicate that plans lack the ability to influence the outcomes measures, possibly due to the reliability concerns. While plans are able to maintain consistent

[2] Kazis, Lewis E., William H. Rogers, James Rothendler, Shirley Qian, Alfredo Selim, Maria Orlando Edelen, Brian D. Stucky, Adam J. Rose, and Emily Butcher, Outcome Performance Measure Development for Persons with Multiple Chronic Conditions. Santa Monica, CA: RAND Corporation, 2017. https://www.rand.org/pubs/research_reports/RR1844.html.

levels of performance in Star measures from HEDIS, CAHPS and other data sources, plans are less able to maintain performance levels in the outcomes measures obtained from HOS.

Recommendation #6d:

BCBSA directionally supports CMS' proposed expansion of the minimum required denominator from 30 to 100. However, we still believe the HOS survey size is extremely small and may not be truly representative, especially for larger plans. We recommend CMS further expand the minimum required denominator as well as the overall sample size that CMS selects for survey distribution.

Rationale #6d:

A larger minimum required denominator and overall sample size will improve the representativeness of the HOS survey.

Issue #7: Proposed Measure Updates: Statin Use in Persons with Diabetes (SUPD) (Part D)

Based on commenter feedback from the 2020 Draft Call Letter, CMS proposes to modify the classification of the SUPD measure category from an intermediate outcome classification to a process measure, starting with the 2023 Star Ratings.

Recommendation #7:

BCBSA supports CMS' proposal to modify the classification of this measure and agrees it is a process, not an outcome measure.

However, we would like to reiterate our comments from the 2021 Advance Notice, in which we requested that CMS keep this measure at a weight of 1 for CY 2019, 2020 and beyond. This is consistent with CMS' language in the 2020 Final Rate Notice, where the agency stated, "For the 2020 Star Ratings, we will keep this measure's weight at 1 as a new measure while we further review this measure's category and consider if CMS should propose to change the technical specifications to reclassify it in the future."

Rationale #7:

BCBSA agrees with CMS that the SUPD measure is a process measure, not an outcome measure, because it requires only a single fill of a statin. In order for a medication to truly contribute to an outcome, it should require measured adherence over a course of treatment. Reclassifying the SUPD measure on an earlier timeline is appropriate given that CMS has proposed returning SUPD to a process measure, and the measure has not changed in any way that would warrant retaining its classification as an interim outcome measure weighted at three.

Issue #8: Proposed Measure Addition: Transitions of Care

CMS proposes two new HEDIS measures for addition in the Part C Star Ratings program for measurement in 2021 (2023 Star Ratings). The first is Transitions of Care, which is the percent of discharges for members 18 years or older who have each of the four indicators during the

measurement year: (1) notification of inpatient admission and discharge; (2) receipt of discharge information; (3) patient engagement after inpatient discharge; and (4) medication reconciliation post discharge. Based on stakeholder input, NCQA is considering several non-substantive measure specification changes, such as broadening the form of communications and changing the timing of notifications and receipts.

Recommendation #8:

BCBSA has significant concerns with this measure, as described in detail in our comments on the 2021 Advance Notice, and does not support it be finalized as proposed.

It is also unclear to BCBSA whether the proposed Transitions of Care measure was actually on display for the 2020 Star Year. The measure described in the Proposed Rule does not exactly match the specifications of any of the Transitions of Care measures currently on the display page. We request that if this actually represents new measure specifications, the measure should remain on display for 2021 before being considered for 2023 Star Ratings at the earliest.

Rationale #8:

We are concerned that the measure in its current form is counter-productive to improving the quality of care of transitions from the inpatient setting to the home. We encourage CMS to ensure the measure indicators include all providers who can appropriately support a beneficiary during a care transition, support transition programs that do not require that a member have a Primary Care Provider visit, and provide measure flexibility due to privacy and administrative limitations.

Additionally, we believe that performance in this measure is largely a function of process and technology on the part of hospitals, and that introduction of this measure would disadvantage plans that manage the care of beneficiaries, especially in rural areas. This furthers the case for extending the time this measure should be on display, because more time is necessary to make the proper investments.

Issue #9: <u>Proposed Measure Addition: Follow-up After Emergency Department (ED) Visit for Patients with Multiple Chronic Conditions</u>

CMS also proposes to add the "Follow-up After Emergency Department (ED) Visit for Patients with Multiple Chronic Conditions" measure in 2021 (for 2023 Star Ratings). This measure is the percentage of ED visits for members 18 years and older who are high-risk multiple chronic conditions who had a follow-up service within seven days of the ED visit. To be eligible for the measure, beneficiaries must have two or more conditions from a specified list. CMS proposes that follow-up services should include: an outpatient visit (with or without telehealth modifier); a behavioral health visit; a telephone visit; transitional care management services; case management visits; and complex care management.

Recommendation #9:

BCBSA does not support CMS' proposal to include this measure in the Stars program. The seven-day timeframe for follow-ups is too short for MA plans to take action, especially since

beneficiaries can go to out-of-network emergency departments, and notification of these visits can be delayed. We encourage CMS to remove or delay this measure and consider whether this measure is better suited as a hospital quality measure.

Rationale #9:

BCBSA supports CMS' goals of ensuring all beneficiaries receive appropriate follow-up care after an ED visit, and we recognize that this measure, in particular, will target the most vulnerable beneficiaries. However, the timeframe proposed in this measure is unworkable for plans, which may not even know that their members have been to an ED within 7 days of that visit. The fact that no prior authorization is required for ED visits means that insurers generally would become aware of ED visits only when claims are submitted. This submission - including the timing - is under the sole influence of facilities indicating varying degrees of claim submission lags e.g., plans may only receive claims well after that one week period has elapsed.

Furthermore, the fact that beneficiaries have equal access to out-of-network EDs as in-network EDs limits plans' abilities to partner with facilities to address this issue. In contrast to the Medication Reconciliation Post Discharge measure, or other Transitions of Care measures where plans are able to effectively manage the measures because the transition of care is done almost exclusively within the confines of a managed care network (i.e., plans working with the providers with whom they contract directly), this is not the case with ED visits. Beneficiaries have the ability to visit all EDs wherever they are located, limiting the influence of MAOs to work with those facilities to address this measure (e.g., if a member visits an out-of-network ED, their plan is unlikely to have had the ability to work with that facility to address this care). This would limit plans' ability to address this important beneficiary need.

Issue #10: <u>Measure Weights</u>

CMS proposes to increase the weight of patient experience/complaints and access measures from two to four. These measures include the patient experience of care measures collected through the CAHPS survey, Members Choosing to Leave the Plan, Appeals, Call Center, and Complaints Measure. CMS estimates that this change would increase overall payments to MA plans by $391.4 million in 2024 and $1.8 billion over 2024-2030. This would somewhat offset the reduction in payments expected from the proposed Tukey outlier deletion methodology.

Recommendation #10:

BCBSA recommends that CMS withdraw the proposal to increase the weights of these measures from two to four.

Rationale #10:

BCBSA shares CMS' goals of empowering patients and recognizes the importance of capturing members' experience, but we respectfully oppose CMS' proposal to increase the weight of patient experience and complaint measures to four, well above the weight of clinical outcome measures. We are concerned about an unprecedented shift away from the objective clinical Star Ratings measures. In particular, Plans raised the following concerns:

- **CAHPs:** As CMS knows, CAHPS measures reflect "member perception of their experience." Changing members' *perceptions* takes significant amount of time and lift by a health plan (this is backed by multiple studies on individual health behavior change). The agency's proposal to increase the weights of member experience measures from two to four represents a significant weight change in an incredibly short period of time. While health plans can mobilize quickly to enact changes with the goal of improving the member experience, it often takes members more than one year to *perceive* an improved experience.

  In addition, for the CAHPs survey, an inherent contract-level rating volatility exists mainly due to the 'last-minute' and 'point-in-time' nature of CAHPS survey questions relative to the contract-year. MA plans already struggle with this volatility and a measure-weight increase will further exacerbate this challenge. Increasing the weight of patient experience measures would make CAHPS a very significant portion of the overall Star Rating. If CMS insists that the weights must be increased, then we would recommend changes to the methodology to ease some of that volatility, allowing plans to be more effective in providing and improving beneficiaries' experiences in a fluid manner.

- **Members Choosing to Leave the Plan:** This area is extremely volatile and can be impacted by many factors beyond a member's experience with their health plan, including job loss/movement, changes in individual finances, provider changing plans, relocations and changes in member needs, among other issues.

  In addition, for this measure, plans are currently penalized even in instances where beneficiaries choose to stay with the same parent organization, but switch contracts that better suit their evolving needs. A weight increase in this measure will hurt MAO Star Ratings further despite continuously striving to offer innovations in their products. The presence of a new innovative product offering does not necessarily indicate the older products are inferior. Rather, new plans are added to accommodate the wide and evolving range of beneficiary needs, where one plan may be optimal for some, but not for others.

Any change regarding the weight of these measures should be preceded by a critical evaluation of the CAHPS and HOS surveys given concerns about decreasing response rates, and the accuracy and reliability of survey results. We encourage CMS to continue to base the Star Ratings on a comprehensive, objective, quality review system. While we appreciate the importance of ensuring patients have a positive experience, and appropriate access to care, we encourage a slower and more thoughtful transition to increasing the weight of patient experience and complaint measures.

Finally, we request clarification from CMS on the definition of the "Call Center." It is unclear if this encompasses the Star measure for prospective members or if this is in reference to the member Customer Service call center.

Issue #11: <u>Extreme and Uncontrollable Circumstances</u>

In previous rule-making, CMS finalized a policy, beginning with the 2022 Star Ratings, for contracts with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas that were affected by disasters that began in one year and were also affected by disasters that began in the previous year. These multiple year-affected contracts will receive the higher of the current year's Star Rating or what the previous year's Star Rating would have been in the absence of any adjustments that took into account the effects of the previous year's disaster for each measure. Those policies also included a provision to address when an affected contract has missing data and specified that, for an affected contract with missing data in the current or previous year, the final measure rating comes from the current year unless an exemption described elsewhere in the regulation applies.

In this rule, CMS proposes to modify and add new text to clarify that missing data includes data where there is a data integrity issue. Under this proposal, when there is a data integrity issue in the current or previous year, the final measure rating comes from the current year.

Recommendation #11a:

BCBSA appreciates CMS' clarification regarding missing data, but continues to recommend that CMS further clarify and/or expand the definition of "extreme and uncontrollable circumstances" to consider scenarios beyond natural disasters, such as fires or floods or unique circumstances outside the current definitions used for this policy, such as epidemics. We request that CMS expand eligibility for the policy in the event of a state or local public health emergency, when the HHS Secretary declares a public health emergency, or in the event of a FEMA emergency or Fire Management Assistance Grant (FMAG) declaration for which public or individual assistance is available.

Rationale #11a:

We appreciate the changes CMS released in the Interim Final Rule related to COVID-19. In the long-term, we encourage CMS to analyze the impact of this pandemic and relief policies on Star Rating to develop an industrywide standard that appropriately measures quality during this type of pandemic and provides all plans with the opportunity to earn a quality bonus payment. It will also be important to understand how the relief policies may have negatively impacted some plans and make adjustments in future rule-making to ensure stability and fairness in the Star Ratings program.

Recommendation #11b:

We continue to recommend that CMS lower the threshold from 25 percent to 20 percent of members impacted by extreme and uncontrollable circumstances and holistically assess the impact of natural disasters on the quality performance of contracts.

Rationale #11b:

While we appreciate CMS' attention to extreme and uncontrollable circumstances that may impact MA and Part D contract performance on Star Rating measures and/or measure level data, we are concerned requiring contracts to have 25 percent of enrollees residing in a FEMA-designated individual assistance area at the time of the extreme and uncontrollable

circumstance is setting the threshold too high. Instead, we encourage CMS to lower the threshold when 20 percent of enrollees are impacted by uncontrollable circumstances, because at this lower percentage, Star Ratings are materially affected.

Recommendation #11c:

BCBSA encourages CMS to look at disasters in aggregate, rather than per incident. We also request clarification on how to calculate the relative percentages of enrollees impacted by the extreme and uncontrollable circumstances policy.

Rationale #11c:

Some BCBS Plans experienced multiple natural disasters in 2019. When the beneficiaries impacted by the disasters are analyzed in aggregate, greater than 25 percent of beneficiaries were impacted. However, the current policy requires that at least 25 percent of enrollees must reside in a FEMA-designated Individual Assistance area at the time of the incident. We encourage CMS to clarify its methodology to look at the aggregate impact of all natural disasters affecting a plan, rather than solely at each incident. Currently, it is unclear how the proposed policy impacts a contract with different members affected by different disasters at different time periods. For example, a group retiree contract with members across the country may not qualify for relief because members experience different disasters in a given year that do not individually meet the 25 percent threshold.

Recommendation #11d:

CMS should reevaluate the application of the extreme and uncontrollable circumstances policy and its applicability to contracts impacted across multiple years and to hold beneficiaries harmless through the improvement measures

Rationale #11d:

Currently, when a contract is impacted across three years, CMS will not grandfather in more than the prior year relief, rather than the prior two years of relief. Additionally, if the plan's Star Ratings are the same, CMS applies the more recent rating, even if the underlying measure scores are not the same. Moving forward, CMS should account for every year the contract experienced an extreme and uncontrollable circumstance. In addition, if a contract gets the same Star Rating in both years, CMS should take the higher of the two years' measure scores in order to ensure that plans and beneficiaries are truly held harmless in the event of a disaster.

Permitting a Second, "Preferred", Specialty Tier in Part D

Issue #1: <u>Permitting Plans to Establish Two Specialty Tiers</u>

Beginning in 2021, CMS proposes to allow Part D plan sponsors to establish up to two specialty tiers.

Recommendation #1:

BCBSA appreciates CMS' proposal to allow plan sponsors to establish up to two specialty tiers. However, as discussed in more detail below, we are concerned that the proposal to retain maximum coinsurance at current levels will lead to higher plan costs, which, in turn, will increase premiums for beneficiaries. BCBSA also notes that due to timing of formulary development and the bid process, even if this proposal is finalized, some plans may not be able to operationalize these changes for 2021.

Rationale #1:

BCBSA appreciates CMS' proposal to establish a second, preferred specialty tier and agrees with CMS that it could improve plans' ability to negotiate with manufacturers, leading to lower costs for beneficiaries. Recent research from actuarial firm Oliver Wyman found that the ability to offer a second specialty tier would increase payer pressure on manufacturers for price concessions, potentially leading to lower direct subsidy payments and savings to the federal government.[3]

Issue #2: Tiering Exceptions

Currently, Part D sponsors may exempt drugs on the specialty tier from their tiering exceptions process.

CMS proposes that if a plan sponsor offers two specialty tiers, they would be required to permit tiering exceptions from the higher cost-sharing specialty tier to the preferred specialty tier if tiering exceptions requirements are met (e.g. when an enrollee cannot take a therapeutic alternative).

Further, consistent with current policy, CMS proposes to specify that if a sponsor offers up to two specialty tiers, the Part D sponsor may design its exception process so that drugs on the specialty tier(s) are not eligible for a tiering exception to non-specialty tiers.

Recommendation #2:

BCBSA supports CMS' proposal to permit Part D plan sponsors to design their exception processes so that drugs on the specialty tier(s) are not eligible for a tiering exception to non-specialty tiers.

If CMS allows exceptions between the two specialty tiers, the agency must balance the potential for beneficiary cost-savings against potential confusion.

Rationale #2:

BCBSA agrees with CMS that maintaining the current policy of exempting specialty tier drugs from tiering exceptions will allow Part D sponsors to negotiate better rebates, ultimately leading to lower costs for beneficiaries and the federal government.

[3] Conway, Brooks and Armstrong, Steven. Evaluating the CMS Proposed Rule to Permit Two Specialty Tiers in Part D. Oliver Wyman. 2020. https://www.oliverwyman.com/content/dam/oliver-wyman/v2/publications/2020/March/OW_CMS_PartD_Specialty_Tiering_Proposal.pdf

Tiering exceptions within the two specialty tiers may be relatively rare and could leave beneficiaries facing complex comparison of different coinsurance rates for drugs with very different prices (as opposed to tiering exceptions in non-specialty tiers where, under many plans, a beneficiary simply sees a lower copayment rate).

Overall, we continue to believe that drug selection should be based on the pricing and positioning on the formulary to maintain transparency to consumers and allow for meaningful negotiations with manufacturers.

Issue #3: Maximum Allowable Cost-Sharing

CMS proposes to codify existing policy, such that the maximum allowable cost-sharing for a specialty tier (or in the case of a plan with two specialty tiers, the higher cost-sharing specialty tier) is 25 percent for plans with the full deductible under the standard benefit, 33 percent for plans with no deductible, and a sliding scale between 25 and 33 percent for plans with a deductible of greater than $0 and less than the defined standard.

CMS also proposes that a plans' second specialty tier (if applicable) must have a maximum allowable cost-sharing that is less than the maximum allowable cost-sharing of the higher cost-sharing specialty tier. However, CMS is not proposing to require a minimum difference between the cost-sharing levels of the two specialty tiers.

Recommendation #3:

BCBSA recommends CMS give Part D plan sponsors more flexibility to set appropriate coinsurance for the two specialty tiers, including the ability to set the non-preferred tier cost-sharing above 25/33 percent.

We support CMS' decision not to propose a minimum difference between the cost-sharing levels of the two specialty tiers and recommend CMS continue to allow plans this flexibility in designing their benefits.

Rationale #3:

As with many Part D policies, we recognize CMS must balance concerns over actuarial equivalence and discriminatory benefit designs in order to strike an appropriate balance between plan flexibility and beneficiary access. However, we are concerned that a reduction in cost-sharing for the preferred specialty tier without the ability to increase cost-sharing for the non-preferred, absent offsetting increases in rebates, could lead to increased costs in premiums or non-specialty coinsurance. We note that the Medicare Payment Advisory Commission (MedPAC) shares these concerns and also recommends CMS provide additional flexibility to set appropriate coinsurance.[4] BCBSA agrees with CMS that ultimately the flexibility to offer two specialty tiers will strengthen the negotiating plan and Pharmacy Benefit Manager (PBM) negotiations with manufacturers in order to drive down prices, but we believe flexibility in setting cost-sharing is critical to the success of this policy.

[4] http://medpac.gov/docs/default-source/comment-letters/04032020_ma_partd_comment_v2_sec.pdf?sfvrsn=0

Issue #4: Tier Composition

CMS does not propose to prescribe which drugs (e.g. generics and biosimilars versus brands and biologics) should be placed on either specialty tier, but notes that placement will be subject to the formulary review and approval process.

Recommendation #4:

BCBSA supports CMS' proposal to maintain flexibility for plans to decide which specialty tier to place drugs on, without prescribing one tier for generics and biosimilars only.

Rationale #4:

Providing plans with flexibility to determine which drugs should be placed on either tier will maximize plans' leverage in negotiations with drug manufacturers and ensure beneficiaries have access to the lowest cost drugs. As we have noted in our comments on the 2021 Advance Notice in response to a potential Star measure related to biosimilar utilization, plans make formulary decisions based on the net cost of a product, which is often, but not always, the generic or biosimilar. Sometimes, when rebates and other price concessions are factored in, the branded biologic may have a net cost to the beneficiary that is lower than the biosimilar drug. In addition, as more pharmaceutical companies pursue an authorized generic strategy, generic drugs may be priced more like brand drugs. Any restrictions on the placement of drugs on the two specialty tiers could have unintended consequences of increasing, rather than decreasing, beneficiary costs.

Issue #5: Codifying the Specialty-Tier Cost Threshold Methodology

CMS proposes to codify, with some modifications, the methodology for determining the specialty cost threshold. Currently, the methodology identifies the top 1 percent of 30-day equivalent PDEs, based on negotiated price. Since 2017, the specialty-tier threshold has been $670.

CMS proposes to codify this methodology, but use the 30-day equivalent ingredient cost instead of negotiated prices. They note that the ingredient cost has fewer variables than the negotiated price and, therefore, represents the most transparent, least complex and most predictable of all the components of negotiated price on which to base threshold determination. CMS does not expect this change to significantly affect the number of Part D drugs meeting the threshold.

Additionally, to maintain stability year-to-year, CMS proposes to undertake an analysis yearly and increase the specialty-tier threshold for a plan year only if CMS determines that no less than a 10 percent increase in the threshold, before rounding to the nearest $10 increment, is needed to reestablish the specialty-tier cost threshold that represents the top 1 percent of 30-day equivalent ingredient costs.

Using the methodology in this Proposed Rule and 2019 PDE data to date, CMS estimates that the specialty-tier threshold for contract year 2021 would be $780 as a 30-day equivalent ingredient cost.

Recommendation #5:

BCBSA supports this proposal.

Rationale #5:

BCBSA agrees with CMS that the ingredient cost is a more transparent and predictable factor than negotiated price.

Beneficiary Real Time Benefit Tool (RTBT)

Issue #1: Requirement to Implement a Beneficiary RTBT

CMS proposes to require Part D sponsors to implement a beneficiary RTBT that would allow enrollees to view accurate, timely and clinically appropriate, patient-specific, real-time formulary and benefit information, effective Jan. 1, 2022.

Recommendation #1:

BCBSA supports CMS' goals of providing out-of-pocket (OOP) drug cost and coverage information to beneficiaries. We recommend CMS delay this requirement by at least one year, to no earlier than Jan. 1, 2023.

Rationale #1:

A delay in effective date will allow plans to incorporate lessons learned from implementation of the prescriber RTBT and provide additional time for the development, testing and wider implementation of an industry standard. Further, CMS should consider lessons learned from the implementation of the changes to the Medicare Plan Finder in terms of the types of information on drug costs that beneficiaries found most useful when selecting a plan, and whether any of those findings are applicable to a beneficiary RTBT.

Issue #2: RTBT Required Elements

The RTBT would be required to include:

- Real-time values for the patient's cost-sharing
- Clinically appropriate formulary alternatives (where appropriate)
- Formulary status of clinically appropriate formulary alternatives, including any utilization management requirements

Recommendation #2:

BCBSA has serious concerns with the requirement for the beneficiary RTBT to include clinically appropriate formulary substitutions and recommends CMS eliminate this requirement.

Rationale #2:

Plans' experience in implementing a prescriber RTBT has identified challenges in providing reliable information on therapeutic alternatives. Specifically, because the categories in the U.S. Pharmacopeia (USP) and other classification systems are not sufficiently granular, the "potential

substitute" suggestions may be meaningless. For example, if a plan uses the USP classification system, drugs to treat diabetes fall under one therapeutic category – Blood Glucose Regulators – which have three therapeutic classes: Antidiabetic agents, Insulins, and Glycemic agents. Within a class, there may be drugs that do not work by the same mechanism of action and are not therapeutically substitutable (e.g. Trulicity® and glipizide within the "Antidiabetic agents" class). It would be misleading to a beneficiary to recommend glipizide as an alternative to Trulicity® despite both agents being used to treat diabetes.

We believe there is value in prescribers having reliable information on therapeutic alternatives given the complexity of identifying appropriate pharmaceutical treatment options. However, this information would not be meaningful for beneficiaries in conversations with their providers, and is more likely to lead to confusion or frustration than help beneficiaries truly identify lower-cost therapeutic alternatives.

Issue #3: Information Not Required

CMS is not proposing to require that beneficiary RTBTs include pharmacy-specific information.

CMS encourages plans to show each drug's negotiated price in addition to the out-of-pocket costs, but does not require this. If the beneficiary RTBT does not show the negotiated price, CMS encourages plans to provide additional cost data comparing the beneficiary and plan cost comparison for each drug and its alternatives.

Recommendation #3:

BCBSA agrees with CMS' proposal not to require that beneficiary RTBTs include pharmacy-specific information or negotiated prices.

Rationale #3:

Providing pharmacy-specific information would be unduly complex. We also agree with CMS that consumers are generally most interested in knowing what they actually need to pay, and terms like "negotiated price" could be unnecessarily confusing.

Issue #4: Rewards and Incentives

CMS proposes to allow plans to offer rewards and incentive (RI) to their enrollees who use the tool. For the purposes of permitted RI, CMS proposes to define "use" as logging into either the portal or application or calling the plan's call center to ask for this information, without regard to whether the enrollee engages in a discussion with his or her prescriber or obtains or switches to any medication in response to such use.

Recommendation #4:

BCBSA supports this proposal.

Rationale #4:

We appreciate the flexibility provided to plans in offering rewards and incentives.

Establishing Pharmacy Performance Measure Reporting Requirements

Issue #1: Disclosure of Pharmacy Performance Measures

CMS proposes to establish a requirement for Part D sponsors to disclose to CMS the pharmacy performance measures they use to evaluate pharmacy performance, as established in their network pharmacy agreement.

CMS believes that this information will allow CMS to better understand the extent to which measures are applied to different pharmacy types, explain pharmacy performance problems, and bring transparency to the process and confirm or dispel the idea that many of the measures may not provide appropriate metrics across all types of pharmacies.

CMS encourages the industry to work together on developing a set of pharmacy performance measures through a consensus process and Part D sponsors to adopt such measures to ensure standardization, transparency and fairness.

Recommendation #1:

BCBSA supports CMS efforts and recognizes the potential value of increased transparency around pharmacy performance measures, but note this should be balanced with the protection of competitive information and acknowledgement of diverse plan, market and pharmacy characteristics that may make standardization challenging.

Rationale #1:

BCBSA appreciates CMS' efforts to ensure beneficiaries have access to high-quality pharmacies that incentivize lower costs and improve health outcomes, and some BCBS Plans are involved in efforts to develop consensus-based pharmacy performance measures through the Pharmacy Quality Alliance (PQA).

Pharmacies play an important role in the health of beneficiaries – especially for those with chronic conditions – and plans use pharmacy performance measures to ensure they can provide high-quality pharmacy networks to their beneficiaries.

We appreciate the role CMS plays in creating alignment between the Part D sponsors, pharmacy retail networks, and medical providers to support better health outcomes and cost reductions. Furthermore, we understand the need for greater consensus among Part D plan sponsors regarding measurement as consistent public reporting supports transparency and fairness among all pharmacies and PBMs. We are encouraged that CMS proposes to continue to rely on the ongoing process being undertaken by PQA and others, prior to issuing any additional data collection guidance. This will help ensure a robust collection of industry accepted, tested, and validated measures.

Medical Loss Ratio (MLR)

Issue #1: Regulatory Changes to Incurred Claims

Under current regulations, the "incurred claims" component of the MLR numerator includes direct claims that the MA organization pays to providers (including under capitation contracts) for covered services (defined as basic benefits, mandatory supplemental benefits, and optional supplemental benefits) that are provided to all enrollees under the contract.

CMS proposes to amend the regulation to remove the specification that incurred claims are payments to providers for covered services. CMS also proposes to remove the specification that incurred claims include payments under capitation contracts with physicians. Finally, CMS proposes to replace the phrase "direct claims," which customarily refers to billing invoices providers submit to payers for reimbursement, with the general term "amounts."

Recommendation #1:

BCBSA supports this proposal. Many BCBS Plans offer supplemental benefits for the chronically ill (SSBCI) that are not delivered by medical providers. Therefore, we appreciate CMS' acknowledgement that SSBCI should be included in the numerator as expenses plans incur to deliver important new flexible supplemental benefits that help address social drivers of health. In addition, given the COVID-19 public health emergency, we encourage CMS to make the same accommodation for costs related to combating the outbreak. It's important that all resources are brought to bear to prevent vulnerable MA beneficiaries from contracting the virus.

Rationale #1:

BCBSA agrees with CMS' assertion that this change will reduce confusion over where spending on supplemental benefits that meet the "primarily health related standard" as well as on "non-primarily health related" supplemental benefits should be counted within the MLR numerator.

Dismissal and Withdrawal of Medicare Part C Organization Determination and Reconsideration and Part D Coverage Determination and Redetermination Requests

Issue #1: Proposed Requirements

Based on inquires, CMS is proposing rules that would apply for withdrawal and dismissal of Parts C organization determinations and reconsiderations and Part D coverage determinations and redeterminations. Specifically, CMS is proposing to permit a plan to dismiss requests when: (1) the individual or entity making the request is not permitted to make the request; (2) the plan determines that the individual or entity making the request failed to make a valid request; (3) the enrollee dies while the request is pending and the enrollee's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the request; or (4) the individual or entity who requested the review submits a timely written request for withdrawal of their request with the plan. CMS is also proposing an avenue to appeal a plan dismissal decision through an IRE.

Recommendation #1:

BCBSA does not believe the proposed definitions provide sufficient clarity around these issues. We are concerned that these definitions address situations where the request for

determination/redetermination was invalid to begin with. In these cases, CMS should consider a new, separate classification that would not imply the request was initially valid.

CMS is proposing to permit a plan to dismiss a request for the initial plan-level coverage determination when the individual or entity who requested the review submits a timely written request for withdrawal. Currently, plans use the withdrawal process, which is a different decision type than a dismissal. We recommend CMS follow the withdrawal process in this scenario, not the dismissal process. In addition, when a beneficiary dies during the request process, we recommend CMS follow the withdrawal process rather than the dismissal process.

In addition, while currently CMS allows parties to withdraw preservice and appeal requests verbally or in writing, this proposal would only allow withdrawals in writing. BCBSA recommends continuing to allow verbal withdrawals because they are more efficient and faster for members, representatives and plans and furthers CMS' "People over Paperwork" initiative.

Rationale #1:

BCBSA does not believe the proposed definitions in this section should address requests that were invalid to begin with.

Furthermore, the agency also seeks comment on whether the proposed rules would create inconsistencies with any state-specific Medicaid procedures pertaining to dismissals or withdrawals. Medicare determination and coverage processes may be different than Medicaid, therefore, if medical care or services are not covered by Medicare, but are covered by Medicaid, withdrawing the appeal is an effective way to minimize the administrative burden of appeals.

We encourage CMS to provide more clarity around the circumstances under which a dismissal process is followed versus a withdraw process and the different expectations associated with these two processes

Section VI: Codifying Existing Part C and D Program Policy

Maximum Out-of-Pocket (MOOP) Limits for Medicare Parts A and B Services

Issue #1: Codifying MOOP Limits

All MA plans (including Employer Group Waiver Plans and SNPs) are required to establish limits on enrollee out-of-pocket cost-sharing for Parts A&B services that do not exceed the annual limits established by CMS.

CMS proposes to codify the current practice of setting the MOOP limits based on a percentile of projected Medicare FFS beneficiary out-of-pocket spending. In addition, beginning in 2022, CMS proposes a new “intermediate” MOOP limit, so that there would be up to three MOOP levels:

- Lower MOOP limit – Any dollar limit that is between zero dollars and up to and including the lower MOOP limit

- Intermediate MOOP limit – Any dollar limit that is above the lower MOOP limit and at or below the intermediate MOOP limit
- Mandatory MOOP limit – Any dollar limit above the intermediate MOOP and at or below the mandatory MOOP limit

The MOOP limit would be rounded to the nearest whole $50 increment.

Recommendation #1:

BCBSA supports the establishment of a third MOOP or voluntary intermediate MOOP limit.

Rationale #1:

The introduction of an intermediate MOOP limit will provide plans with the option of offering more flexible benefit designs to deliver more high-value plan options to beneficiaries. This flexibility is increasingly important as CMS has allowed sponsors to develop specialized plans that are better tailored to beneficiaries' chronic conditions.

Issue #2: ESRD Cost Transition

CMS proposes a multi-year transition from their current practice of excluding costs of beneficiaries with ESRD to including all related costs in the FFS data that is used to set MOOP.

The ESRD cost differential is defined as the difference between projected OOP costs for beneficiaries using Medicare FFS data excluding the costs incurred by beneficiaries with ESRD diagnoses for contract year 2021 (95th percentile = $7,175; 85th percentile = $3,360), and the projected OOP costs for all beneficiaries using Medicare FFS data (including costs incurred by beneficiaries with ESRD)

- For 2022 – CMS factors in 60 percent of the ESRD cost differential
- For 2023 or the next year of the ESRD cost transition – CMS factors in 80 percent of the ESRD cost differential
- For 2024 or the final year of the ESRD cost transition and beyond – CMS uses complete Medicare FFS data that includes the OOP costs incurred by beneficiaries with and without diagnoses of ESRD

Recommendation #2:

BCBSA supports the multi-year transition for including the costs of beneficiaries with ESRD in setting the maximum allowable MOOP. In our comment letter on the 2021 Part C Benefits Review and Evaluation memorandum, BCBSA recommended an increase of $3 PMPM to $39 PMPM for the TBC change threshold for 2021. We recommend that CMS consider increases to TBC change thresholds for 2022 and beyond to accommodate the increase in MOOPs.

Rationale #2:

The maximum allowable MOOP increase will provide flexibility to plans to adjust to the costs of covering ESRD beneficiaries. However, since the ESRD payment rates are inadequate, other

MA beneficiaries will be subsidizing the additional cost due to ESRD beneficiaries through additional cost-sharing or increased premiums. The transition schedule will allow for a more gradual implementation of higher MOOPs and provide some limits on the impacts to beneficiaries.

Plan Crosswalks for MA Plans and Cost Plans

Issue #1: Codifying Existing Policy

CMS proposes to codify the current process and conditions under which MA organizations and 1876 cost plans can transfer their enrollees into the same plan or plan type from year to year when no other election has been made (known as a "plan crosswalk").

CMS also codifies the requirements that protect a beneficiary's right to choose a plan and specifies when a MA organization or cost plans can transfer their enrollees to other plans of a different type offered by the same MA organization or cost plan (referred to as a "crosswalk exception).

CMS is proposing to codify existing policy regarding plan crosswalks, implement rules to protect a beneficiary's right to choose a plan, and describe allowable circumstances under which MA organizations may transfer beneficiaries from one of its plans into another, or a cost contract may transfer beneficiaries from one of its plans into another.

Recommendation/Rationale #1:

BCSBA supports CMS' proposal to codify crosswalk and crosswalk exception processes and conditions. However, we request CMS provide clarification as to whether two different ANOCs would be required in situations in which a plan crosswalks beneficiaries into two different plans.

MA Change of Ownership Limited to the Medicare Book of Business

Issue #1: Change of Ownership

Under existing practice and contracting regulations, when an MA organization changes ownership, the execution of a novation agreement is required for a transfer of ownership to a new entity. CMS states that it has been its long-standing practice to only permit such MA contract novation for transfers involving the organization's entire line of MA business.

CMS proposes to codify explicitly that CMS will not recognize or allow a sale or transfer that consists solely of the sale of transfer of individual beneficiaries, groups of beneficiaries enrolled in a plan benefit package, or one MA contract if the organization holds more than one MA contract.

CMS will not recognize the sale or transfer of just one MA contract because it states that it could have a negative effect on beneficiary election rights.

Recommendation #1:

BCBSA recognizes that this is a long-standing policy, but notes that some BCBS Plans believe this rule is overly restrictive and limits an MAO's ability to ensure a smooth transition for enrollees if the plan decides to exit a contract.

Rationale #1:

CMS' proposal would remove a viable option for a plan to transfer a contract with minimal disruption to enrollees, especially because the enrollee would move within the contract, and, ideally, the move would be invisible to the enrollee. This limitation would require a plan to retain a contract that is not working and force them to exit the MA market entirely in order to close an underperforming contract.

MA and Cost Plan Network Adequacy

Issue #1: Codifying Existing Network Adequacy Standards

CMS proposes to codify existing network adequacy standards to provide MA organizations with a greater understanding of how CMS measures and assesses network adequacy.

CMS proposes to codify the list of provider and facility specialty types subject to network adequacy reviews, county type designations and ratios, maximum time and distance standards, and minimum number requirements and exceptions.

Recommendation #1:

BCBSA supports CMS' proposed flexibilities to the MA network adequacy requirements, as described in detail below.

Rationale #1:

CMS' proposed approach reflects the challenges associated with establishing a network in some geographies and would improve beneficiaries' access to plan options in rural areas and access to telehealth innovations to close care gaps.

Issue #2: New Network Adequacy Provisions

While the majority of the provisions proposed here would codify existing guidance and current practices, CMS proposes several new provisions, primarily intended to increase access to MA in rural areas.

- Percentage of Beneficiaries Residing Within Maximum Time and Distance Standards. CMS has historically required that, in order to meet the time and distance standards, at least 90 percent of beneficiaries must have access to at least one provider and facility of each specialty type within the county. CMS proposes to reduce this percentage to 85 percent in Micro, Rural and Counties with Extreme Access Considerations (CEAC) counties.
- Bonus for Coverage of Telehealth Services: CMS proposes to give an MA plan a 10 percentage point credit towards the percentage of beneficiaries residing within the applicable time and distance standards for certain provider specialty types when the plan contracts with

telehealth providers. This telehealth credit would be applied only to specific provider specialty types: dermatology, psychiatry, neurology, otolaryngology and cardiology.

- Bonus for Beneficiaries Affected by State Certificate of Need (CON) Laws: CMS proposes to give an MA plan a 10 percentage point credit towards the percentage of beneficiaries residing within applicable time and distance standards for affected provider and facility types in states that have CON laws, or other state imposed competitive restrictions, that limit the number of providers or facilities in a county or state.

Recommendation #2:

Overall, BCBSA believes that a revision of the health service deliver (HSD) tables are needed and network adequacy should be based more on type of care than numeric tables. BCBSA supports CMS' new proposals to provide flexibility in network adequacy requirements, especially in rural areas. Regarding telehealth, we continue to encourage CMS to allow diagnoses and other encounter data from telehealth services to be used for the purposes of risk adjustment, especially as we see how quickly non-emergent care can be moved to the remote space such as what we are seeing during the COVID-19 crisis. BCSBA recommends that CMS expand the proposed list of provider specialty types eligible for the telehealth network adequacy credit to include other behavioral health specialties (in addition to psychiatry), internal medicine, pediatrics, family practice, obstetrics and gynecology, and endocrinology.

We understand the types of eligible providers have been expanded during the current national emergency, and we request CMS consider such an expansion of eligible providers after the end of the current national emergency.

Rationale #2:

This new flexibility acknowledges the challenges with establishing a network in some geographies and would improve beneficiaries' access to plan options and access to telehealth innovations to close care gaps. Given the challenges associated with the COVID-19 outbreak, we appreciate that CMS has proposed flexibilities when plans contract with telehealth providers.

General practitioners are the main provider groups helping to triage and reduce unnecessary ED utilization by providing virtual visits to their patients. In addition, many Medicare beneficiaries frequently see endocrinologists due to diabetes and other complications. Expanding telehealth credits to these provider groups can improve access to care for Medicare beneficiaries and help them better manage their chronic conditions.

Issue #3: Options to Improve Access to Dialysis Services

CMS is also considering options to improve access to dialysis services, and solicits comments on:

> (1) Whether outpatient dialysis should be removed from the list of facility types subject to time and distance standards.
>
> (2) Allowing plans to attest to providing medically necessary dialysis services in its contract application (as is current practice for DME, home health and transplant

services) instead of requiring time and distance standards for providers of these services be met.

(3) Allowing exceptions to time and distance standards if a plan is covering home dialysis for all enrollees who need these services.

(4) Customizing time and distance standards for dialysis facilities.

Recommendation #3: Given the expected increase in ESRD beneficiary enrollment in MA, BCBSA recommends removal of outpatient dialysis from the list of facility types for which MA plans must meet time and distance standards and allowing plans to attest to providing medically necessary dialysis services in contract applications.

Rationale #3:

These flexibilities will encourage competition, bring down high reimbursement costs, and drive patient-centered innovation in dialysis treatment. We understand that these facilities and the services they provide are critical to the members that need them, but we believe that removing these facilities from the necessary time and distance standards is one way to address their skewed market power, as is allowing plans to attest to providing the services in their contract applications.

Supplemental Benefit Requirements

Issue #1: Definition of Supplemental Benefits

CMS proposes to codify existing guidance related to supplemental benefits, its recent reinterpretation of benefits that are primarily health-related and its recent reinterpretation of uniformity requirements.

Recommendation #1:

BCBSA agrees with these provisions and recommends they be adopted as proposed. We request that CMS allow geographic flexibility to offer supplemental benefits at a county level within a multi-county service area plan.

Rationale #1:

Many of the organizations that a health plan would partner with to offer supplemental benefits are community based and do not have capacity to provide benefits to a multi-county service area. This means that plans have to partner with larger, national organizations rather than the community organizations that may be better suited to address the needs of the beneficiaries in the region and better able to target interventions.

Issue #2: Uniformity Flexibility

CMS also proposes to codify in §422.100(d)(2)(ii) its reinterpretation of uniformity flexibility that permits MA plans to meet uniformity flexibility requirements by providing supplemental benefits

(such as specific reductions in cost-sharing or additional services or items) that are tied to disease state or health status in a manner that ensures that similarly situated individuals are treated uniformly. The Proposed Rule would state that and would require that there be a nexus between the health status or disease state and the specific benefit package designed for enrollees meeting that health status or disease state.

Recommendation #2:

BCBSA supports CMS' reinterpretation of uniform flexibility and codifying it in regulation.

Rationale #2:

CMS' reinterpretation of uniform flexibility provides plans with necessary tools to design benefits that best meet the needs of their beneficiaries.

Rewards and Incentives Program Regulations for Part C Enrollees

Issue #1: Proposed Changes to Rewards and Incentives Programs

CMS proposes several changes to Reward and Incentive (R&I) programs in response to many questions the agency has received over the years. First, CMS proposes rewards must be provided to an enrollee in the same contract year as the rewardable activity. Second, CMS proposes to limit mid-year R&I program changes.

Recommendation #1a:

BCBSA does not believe CMS should finalize its proposal to cap utilization of rewards within the contract year.

Rationale #1a:

BCBSA appreciates CMS' emphasis on MA beneficiary experience with R&I programs by ensuring plans provide reward item to enrollees in the same contract year. However, there are concerns with regards to instances where members complete rewardable activities towards the end of a contract year. Delay in plan notification and general end-of-year claims data lag could create operational complications for plan R&I programs to be entirely compliant.

Recommendation #1b:

BCBSA does not believe CMS should finalize its proposal to limit mid-year R&I program changes. CMS should continue to allow these changes so that programs can cater to evolving member needs throughout a program year.

Recommendation #1b:

We also recommend CMS continue mid-year changes to MA plan R&I programs to allow MA plans to drive quality in clinical outcomes and ensure care and motivation for beneficiaries to get appropriate preventative screenings.

Rationale #1b:

Disallowing changes during the contract year could limit plans' ability to provide adequate incentives for members to get preventative screenings and manage certain medical conditions. Furthermore, taking away flexibility of changing R&I programs within a contract year would also limit plans' ability to offer rewards that may help members respond in a timely manner to activities promoting improved heath in response to public health crises e.g., COVID-19.

Requirements for Medicare Communications and Marketing

Issue #1: Codifying Guidance

CMS is proposing to codify and further define the sub-regulatory guidance in the Medicare Communications & Marketing Guidelines (MCMG). The reorganization of existing regulations is not intended to change the policies contained therein.

CMS notes that the MCMG prohibits plans from sending unsolicited materials that call out the opportunity afforded by the OEP, using mailing lists or other anecdotal information to target individuals who made enrollment requests during the annual coordinated enrollment period or leveraging agent/broker activities that target the OEP as a way to make further sales.

Recommendation #1:

BCBSA has the following recommendations and questions regarding the proposals at 42 C.F.R. § 422:

- 422.2262(b)(1)(iv). CMS should clarify what it means by "use of a previous post?" It is unclear what types of social media ads would be considered product endorsements or testimonials.
- 422.2262(c)(1)(i). CMS should clarify whether the MCMG or this regulation would control? Here, CMS includes the requirement to add the hours of operation to any customer service number, but in the MCMG for 2019, CMS removed this requirement to include the hours of operation.
- 422.2266(b). The sentence should be revised to say ". . . including but not limited to," rather than ". . . including, are not limited to . . .".
- 422.2267(e). This sentence should be revised to say ". . . must be provided to current and/or prospective enrollees," rather than ". . . must be provided to current and or perspective enrollees . . ."
- 422.2267(e)(30)(ii).
    - CMS should consider including, as an exception, envelopes, ID cards and call scripts, as allowed per the MCMG.
    - CMS should consider including these exceptions for all disclaimers, rather than only for the Federal Contracting Statement, as allowed per the MCMG.

BCBSA has the following recommendations and questions regarding the proposals at 42 C.F.R. § 423:

- 423.2262(b)(1)(iv). CMS should clarify what it means by "use of a previous post?" It is unclear what types of social media ads would be considered product endorsements or testimonials.

- 423.2262(c)(1)(i). CMS should clarify whether the MCMG or this regulation would control? Here, CMS includes the requirement to add the hours of operation to any customer service number, but in the MCMG for 2019, CMS removed this requirement to include the hours of operation.
- 423.2267(e). This sentence should be revised to say ". . . must be provided to current and/or prospective enrollees," rather than ". . . must be provided to current and or perspective enrollees . . .".
- 423.2267(e)(32)(ii).
    - CMS should consider including, as an exception, envelopes, ID cards and call scripts, as allowed per the MCMG.
    - CMS should consider including these exceptions for all disclaimers, rather than only for the Federal Contracting Statement, as allowed per the MCMG.

Rationale #1:

These recommended edits and clarifications will help ensure BCBS plans can remain compliant with all CMS communications and marketing requirements.

Past Performance

Issue #1: Codifying Guidance

CMS proposes to adopt an updated past performance methodology that uses a three-pronged test as basis for denying an MA or Part D application: (1) the imposition of civil money penalties (CMPs) or intermediate sanctions; (2) failure to achieve at least a three-star Part C or Part D summary rating in the set of Star Ratings CMS issued during the 12-month review period; and (3) failure to maintain a fiscally sound operation.

Recommendation #1:

BCBSA appreciates CMS' efforts to clarify and simplify the past performance methodology; however, we are concerned that this proposal would be overly restrictive in its application. We encourage CMS to consider the factors in combination, as well as the size of the identified contract. Additionally, we believe CMS should use at least two years of Star Ratings performance to allow for improvement efforts to be measured and reported. Finally, given the narrow time frame CMS proposes for review, BCBSA requests that plans should be provided a remediation opportunity and an appeals process should the plan quickly address the identified issues.

Rationale #1:

BCBSA understands the need to restrict the ability of poor performing plans to expand, particularly for plans with a history of poor performance under the current past performance standards. However, we do not believe the proposed methodology sufficiently takes into account the nature and context of performance issues over a sufficient period of time and, thus, would inadvertently limit new high-quality plan offerings.

With low Star Ratings, for example, if a large organization acquires a struggling MA plan with the goals of improving its performance; it would be reasonable for that organization to focus on

improving the contract in that geography, but unduly restrictive to stop that organization from applying for any new contracts across the country. To address this issue, we would ask CMS to consider at least two years (and preferably three years) of Star Ratings performance to allow for improvement efforts to be measured and reported.

CMS notes that the agency intends to exclude intermediate sanctions imposed on D-SNPs (2021 through 2025) as a basis for denying a MA or Part D application. We appreciate CMS' acknowledgement that given the new requirements of the BBA 2018, more intermediate sanctions may not be tied to overall contract performance.

Call Center Requirements

Issue #1: General

MAOs and Part D sponsors are required to have in place a toll-free customer service call center. CMS proposes changes to existing call center requirements to add specificity.

Recommendation #1:

Our interpretation of the proposed requirements for call center hours is that CMS is putting into regulation the existing requirements that exist in section 80.2 of the current Medicare Communications and Marketing Guidelines. CMS should clearly reflect that this is existing policy in the final regulation.

Rationale #1:

BCBSA appreciates CMS' efforts to provide explicit performance standards for MA and Part D customer service call centers and ensure protections for beneficiaries.

TAB 6

As of: January 25, 2024
Received: April 06, 2020
Status: Posted
Posted: April 10, 2020
Tracking No. 1k4-9fz7-cikf
Comments Due: April 06, 2020
Submission Type: Web

PUBLIC SUBMISSION

Docket: CMS-2020-0010
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2021 (CMS-4190-P)

Comment On: CMS-2020-0010-0002
Medicare and Medicaid Programs: Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Document: CMS-2020-0010-0468
Comment on CMS-2020-0010-0002

Submitter Information

Name: Anonymous Anonymous
Address:
Washington, DC, 20001
Email: kconnor@ahip.org
Organization: America's Health Insurance Plans

General Comment

Please see attached comment letter.

Attachments

AHIP Comment Letter on MA Proposed Rule CY2021-2022 - 4-6-2020_wakelyreportsattached

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

Matthew Eyles
President & Chief Executive Officer

April 6, 2020

Ms. Seema Verma, Administrator
Centers for Medicare & Medicaid Services (CMS)
Attention: CMS–4190–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly ("Proposed Rule")

Dear Administrator Verma:

America's Health Insurance Plans (AHIP)[1] appreciates the opportunity to comment on the Proposed Rule. As we submit these comments in the middle of the COVID-19 pandemic, a public health emergency that is unprecedented in its scale and impact, we sincerely hope that you and the entire CMS team are safe, healthy, and well. This crisis is subjecting all sectors of the country to unforeseen and extraordinary challenges. We commend you, the CMS leadership team, and the CMS staff for the tireless work across the agency and the steps that CMS has already taken to expand flexibility and reduce unnecessary burdens on doctors, hospitals, health insurance providers, and other stakeholders so they can best focus on responding to the challenges.

Enormous uncertainties about the scope, cost, duration, and ultimate impact of the COVID-19 crisis remain that could have significant and unforeseen effects on the Medicare Advantage (MA) and Part D programs in 2021. We have separately provided CMS with recommendations on ways to further revise program requirements and address actuarial uncertainties that are affecting both current 2020 operations and the ability of MA and Part D plans to prepare bids for the 2021 plan year. These changes are essential to ensuring program stability for enrollees, providers, taxpayers, and other affected parties. We urge the agency to act swiftly to address MA plan issues that are critical to ensure the delivery of optimal and stable plan benefits and timely and effective communications and information flow. Our comments here will focus on the MA and Part D proposals in the Proposed Rule, although we will highlight COVID-19-specific issues where particularly relevant.

[1] AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day, including those enrolled in Medicare Advantage (MA), Medicare Part D, Medicaid, and PACE. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

The Value of MA and Part D, and Policy Proposals That Will Enhance Their Value

The Value of Medicare Advantage and Part D. The MA and Part D programs are models of consumer choice, competition, and innovation that help deliver high-quality, affordable coverage and care to tens of millions of Americans. More than 24 million people – 35% of those eligible for Medicare – are now enrolled in MA, and the program continues to grow dramatically year by year. Moreover, 47 million Americans are enrolled in Part D, a program that has been a model of consumer choice and market competition and has improved access to prescription drugs while reducing out-of-pocket costs.

Seniors and people with disabilities increasingly choose MA over the traditional Medicare program and consistently indicate high satisfaction rates.[2] MA plans work with members to prevent, detect, and manage chronic conditions. MA plans offer more comprehensive types of benefits and services, including telehealth and benefits such as nutrition, transportation, and in-home services, which help address various social barriers to better health. Furthermore, plans offer more financial security than traditional Medicare by capping enrollee annual out-of-pocket costs and in many cases providing drug coverage for no additional cost.[3] MA plans outperform traditional Medicare on clinical quality measures[4], survival rates[5], hospital readmissions and patient days spent in rehabilitation facilities and nursing homes[6,7], and hospital use in the last days of life.[8] A newly released study concluded that MA enrollees with Alzheimer disease and related dementias had lower rates of health care utilization than traditional Medicare beneficiaries without compromising care satisfaction or health status, suggesting MA plans may be more efficient at delivering care for this patient population.[9]

In this regard, MA is not only a good deal for seniors; it is cost effective for taxpayers. Plan bids for delivering the basic Medicare benefit have been well below traditional Medicare costs for several years and are now 88% of traditional Medicare costs, based on the latest Medicare Payment Advisory Commission (MedPAC) estimates. Further, according to MedPAC, average payments to MA plans in

---

[2] A recent survey finds 93% of MA members reporting satisfaction with their health care coverage, 91% satisfied with their preventive services, and 88% satisfied with their prescription drug coverage. More than 90% of MA members would recommend it to their friends and family. Morning Consult National Poll. December 10-17, 2019. Available online at: https://medicarechoices.org/americans-like-ma/

[3] Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy. March 2020.

[4] Timbie, Justin W., Bogart, Andy, Damberg, Cheryl et al. Medicare Advantage and fee-for-service performance on clinical quality and patient experience measures: Comparisons from three large states. *Health Services Research* 52(6), Part I: 2038-2060. December 2017.

[5] Mandal, Aloke K., Tagomori, Gene K., Felix, Randell V. et al. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. *American Journal of Managed Care* 23(2): e41-e49. February 2017.

[6] Kumar, Amit, Rahman, Momotazur, Trivedi, Amal N. et al. Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data. *PLoSMed* 15(6): e1002592.

[7] Huckfeldt, Peter J., Escarce, Jose J., Rabideau, Brendan, et al. Less intense post-acute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service. *Health Affairs* 36(1): 91-100. January 2017.

[8] Teno, Joan M., Gozalo, Pedro, Trivedi, Amal N. et al. Site of death, place of care, and health care transitions among US Medicare beneficiaries, 2000-2015. *JAMA* Published online June 25, 2018.

[9] Park, S., White, L., Fishman, P. Medicare Advantage and traditional Medicare beneficiaries with and without Alzheimer disease and related dementias. *JAMA Network Open* 3(3): e201809. March 2020.

2020 are equivalent to traditional Medicare costs – and have been since 2017 – while offering supplemental benefits and enhanced financial security for seniors.[10] And in areas of the country where MA enrollment is higher relative to traditional Medicare, additional MA enrollment leads to slower traditional Medicare spending growth as providers employ MA practice patterns and care guidelines for their remaining traditional Medicare patients.[11]

Policies That Enhance the Value of MA and Part D. AHIP encourages policies that expand flexibility, choice, competition, and value in MA and Part D because these programs are critical to achieving national policy goals for improved health care. CMS has taken numerous steps in recent years to strengthen MA and Part D. They include adding new benefit flexibilities and reducing certain unnecessary administrative burdens. We commend CMS for those actions, and for including a number of policies in the Proposed Rule that will further support the delivery of better care and better value through innovative, patient-centered programs that improve quality and reduce costs for seniors and others eligible for Medicare. For example:

- **Flexibility in Dialysis Care Delivery.** We strongly support certain proposals that CMS is considering to enhance MA plan flexibility in network adequacy standards for dialysis facilities. The flexibility would promote innovation, increase access, and reduce costs for people with end-stage renal disease (ESRD). AHIP has consistently raised serious concerns about the negative effects of consolidation among dialysis providers. The Administration has been a leader in taking steps to encourage more Americans to obtain treatment outside dialysis centers through home dialysis and other alternative delivery methods, including through Innovation Center models designed to overhaul the delivery of kidney care. These steps are even more important given the COVID-19 public health emergency. COVID-19 highlights the vulnerabilities of people with serious illness and/or a compromised immune system, and the need to have a viable treatment infrastructure that allows them to access life-saving dialysis services while protecting them from exposure to infection. Although MA plans already employ new ways to improve health and outcomes for people with ESRD, advancements in dialysis technology combined with more flexible network standards can ensure patient protections while helping MA plans further deliver on the goals articulated in the Administration's Advancing American Kidney Health Initiative.

- **Flexibility to Expand Telehealth and Rural Access and Address Anti-Competitive State Laws.** CMS is proposing network flexibility to increase competition and access for enrollees using emerging telehealth technologies, as well as for those living in rural areas. These flexibilities would also address anti-competitive restrictions like certificate of need laws in certain states. We strongly support these steps. The COVID-19 pandemic also reinforces the need for CMS to continue exploring additional flexibilities that promote innovative ways for patients to access medical services when traditional time and distance standards may not be an appropriate means of measuring access to care.

[10] Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy. March 2020.
[11] Johnson, Garret, Figuero, Jose F., Zhou, Xiner, et al. Recent growth in Medicare Advantage enrollment associated with decreased fee-for-service spending in certain US counties. *Health Affairs* 35(9): 1707-1715. September 2016.

- **Expanded Negotiating Tools in Part D.** CMS' proposal to expand private-sector negotiating tools in Part D by allowing a second "specialty" tier will help to expand competition among manufacturers. Greater competition will allow plans to obtain larger price savings from manufacturers and encourage Part D enrollees to use more cost-effective drugs. The result will be lower patient cost-sharing and lower beneficiary premiums, savings for plan customers like employers and states, and reduced costs for taxpayers.

- **Encouragement of Supplemental Benefits.** We commend CMS for a proposed regulatory change that will ensure all amounts paid for covered services, including expanded supplemental benefits are counted as covered medical expenses for medical loss ratio purposes. The change will enhance the ability of MA plans to offer benefits that address social barriers to care and other needs of chronically ill enrollees.

Policy Proposals That Would Limit Choice and Innovation and Diminish Program Value

We are concerned that several proposals in the Proposed Rule are inconsistent with the goals of the MA program because they could undermine choice, benefits, and costs for Americans and diminish the value of the program.

- **Limits on Certain MA Plans Attractive to Dually Eligible Enrollees.** A proposal to eliminate certain MA plans that enroll a significant number of individuals dually eligible for Medicare and Medicaid could disrupt their care and prevent them from accessing coverage that may best meet their needs. "Partial dual eligibles" – people who receive help paying Medicare premiums and cost-sharing but not the full array of Medicaid benefits – could lose access to benefits not otherwise available to them. While we strongly support enhanced integration of Medicare and Medicaid benefits for dual eligibles and appreciate CMS' goal to encourage more integration, we believe the proposal would have adverse, unintended consequences. We urge CMS to explore more flexible approaches.

- **Cut Point Changes for Star Ratings.** We have significant concerns with CMS' proposal to exclude performance "outliers" when setting cut points for certain Star Ratings measures. We believe there are flaws in the proposed methodology. Moreover, the magnitude of reductions in Star Ratings would adversely affect premiums and supplemental benefits; an analysis by Wakely Consulting Group[12] found that CMS may have significantly underestimated such negative impacts.[13] Nearly one-quarter of MA contracts could have their performance reduced by 0.5 Stars as a result of the methodology change. We appreciate CMS' desire to increase predictability and stability of cut points, but we continue to urge the agency to reinstate the policy that will best achieve those objectives: predetermined cut points in advance of the measurement period.

[12] Wakely Consulting Group. Proposed Rule Changes to the Medicare Star Rating Program: Analyzing the Impact of Proposed Changes on Medicare Advantage Spending. March 2020.
[13] Reductions relating to 2024 MA spending (based on 2023 Star Ratings) are estimated to be $1.4 billion, which is nearly 2 times more than CMS estimated.

- **Emphasis of Survey Data Over Clinical Outcomes in Star Ratings.** We have significant concerns with a proposal to change the Star Ratings program by increasing the weight of patient experience/complaints and access measures relative to other measures. These measures are based on a limited sample that may yield inaccurate, unreliable, or biased data, which will be further affected by extraordinary events like the COVID-19 public health emergency. Overweighting survey or administrative data compared to clinical outcomes does not align with CMS' guiding principles for the Star Ratings program, which include focusing on measures that are developed by consensus-based organizations; that treat contracts fairly and equally; that are based on accurate, complete, and reliable data; and that are subject to improvement based on factors under a plan's control. An analysis by Wakely found significant year-over-year volatility in average Star Ratings for these measures despite consistent trends in plan performance over time. Increasing the weights for these measures has the potential to erode the integrity of the Star Ratings program – by basing the majority of the Star Rating score on such measures where the correlation between average contract performance and Star Ratings is unclear.[14] Finally, while CMS indicates that this change would actually have a positive impact on Star Ratings, Wakely also found that the impact on MA spending in the first affected year, 2024, would be minimal – and nearly 5 times less than CMS estimated.[15] When combined with the proposal to exclude outliers, more MA enrollees would be in plans negatively impacted than those who would see positive results.

- **Calculation of Certain ESRD Costs Excluded from MA Benchmarks.** We remain concerned with the methodology CMS proposes to exclude organ acquisition costs for kidney transplant from MA benchmarks. The magnitude of the cost carve-outs and the resulting impacts on premiums and benefits could be very significant in many urban areas. Given the potential impacts on all MA enrollees, we reiterate the request in our comments on the CY 2021 Advance Notice that CMS provide more transparency regarding the calculation of the carve-out factors.

Timelines

As noted in our comments on the Advance Notice, several policies in the Proposed Rule would have important impacts on the costs and/or benefits available to MA and Part D enrollees in 2021. Given the late release of CMS' rulemaking for 2021, we remain concerned about the uncertainty affecting plans that attempt to incorporate changes into projected costs or benefit designs for 2021 bids, which are due June 1, 2020. The COVID-19 crisis has obviously injected even more uncertainty into the bid process.

Therefore, to the extent CMS moves forward with the Proposed Rule, we ask CMS to finalize all proposals with significant impacts on 2021 benefits that AHIP and its member plans support as quickly as possible separately from other parts of the Proposed Rule. At the same time, ***in recognition of the current environment, we ask CMS to consider making all new 2021 obligations***

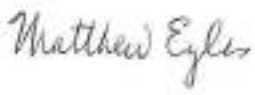
[14] Wakely Consulting Group. Star Rating Variability of Patient Experience and Access Measures: Analyzing the Impact of Variable Star Rating Cut Points and Measure Level Results. March 2020.
[15] Wakely used 2020 Star Rating performance data (more recent than 2018 data used by CMS). See: Wakely Consulting Group. Proposed Rule Changes to the Medicare Star Rating Program: Analyzing the Impact of Proposed Changes on Medicare Advantage Spending. March 2020.

in the Proposed Rule voluntary rather than mandatory. The effective date for mandatory compliance could be deferred until 2022. This would help plans limit as much as possible the uncertainties surrounding the bid process. It would also enable them to best focus resources on helping patients and providers in 2020, and supporting implementation of CMS initiatives directed to the COVID-19 emergency.

Conclusion

Again, we appreciate the opportunity to comment on the Proposed Rule and the tremendous efforts across the agency to move the MA and Part D programs forward amidst the unprecedented challenges our nation faces due to COVID-19. Attached are detailed comments on the foregoing proposals and other provisions in the Proposed Rule. Our recommended changes are aimed at maintaining and growing strong and stable MA and Part D programs so millions of seniors and people with disabilities continue to receive the high-quality, coordinated care they deserve and rely on. We look forward to continuing to work together on policies that ensure affordable and innovative choices in MA and Part D to improve the health and well-being of Americans.

Sincerely,



Matthew Eyles
President & Chief Executive Officer

AHIP Detailed Comments on CMS Proposed Rule

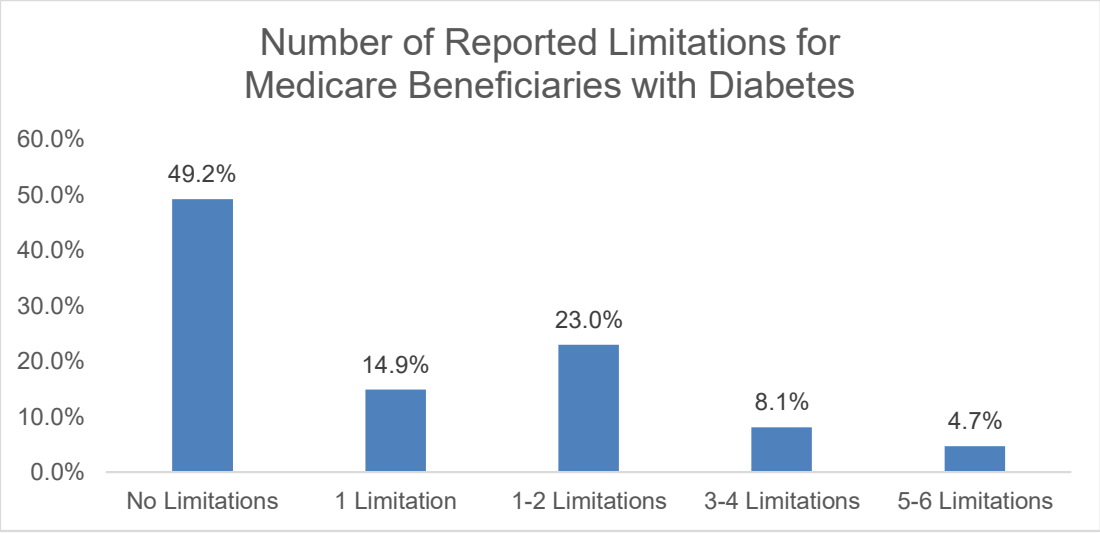
Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

II. Implementation of Certain Provisions of the Bipartisan Budget Act of 2018

A. Special Supplemental Benefits for the Chronically Ill (SSBCI) (§ 422.102)

CMS proposes to codify in regulation, with some modifications, existing SSBCI sub-regulatory guidance and statutory parameters, including those defining SSBCI and chronic conditions. One of the modifications that CMS proposes to make is to allow plans to cover chronic conditions beyond those included on the list of eligible conditions established by the panel of clinical advisors.

Recommendation: AHIP strongly supports the proposed additional flexibility that would enable plans to continue to innovate around providing supplemental benefits for their chronically ill enrollees. There are noted variations in functional status among Medicare beneficiaries with chronic conditions, like diabetes and arthritis, in the literature.[16] For example, as illustrated by the latest Medicare Current Beneficiary Survey (MCBS) data available, nearly half of diabetic beneficiaries report no functional limitations (see chart below).



Source: Analysis of 2017 MCBS Public Use File, Fall panel.

[16] For example, see Stineman, Margaret G., et al. Establishing an approach to activity of daily living and instrumental activity of daily living staging in the United States adult community-dwelling Medicare population. *PM & R: the journal of injury, function, and rehabilitation* 6.11 (2014): 976; Jindai, Kazuaki, et al. Peer reviewed: Multimorbidity and functional limitations among adults 65 or older, NHANES 2005-2012. *Preventing chronic disease* 13 (2016); and Barile, John P., et al. Peer reviewed: Patterns of chronic conditions and their associations with behaviors and quality of life, 2010. *Preventing chronic disease* 12 (2015).

Accordingly, we recommend that CMS enhance the existing flexibility by permitting plans to tailor SSBCI to the functional status of enrollees with a given chronic condition, so plans can provide the most targeted benefits to chronically ill enrollees whose health or overall function could be improved or maintained with SSBCI. We believe this is consistent with Section 1852(a)(3)(D)(ii) of the Social Security Act (the Act), which defines a chronically ill enrollee as a beneficiary with one or more comorbid and medically complex chronic conditions that is either life threatening or significantly limits the overall health or function of the enrollee.

B. Improvements to Care Management Requirements for Special Needs Plans (SNPs) (§ 422.101)

CMS proposes at §422.101 to extend existing care management requirements for chronic condition special needs plans (C-SNPs) to dual eligible (D-SNPs) and institutional SNPs (I-SNPs). These requirements include: an interdisciplinary care team (IDCT) for each enrollee, face-to-face encounters with each enrollee (in person or via telehealth) at least annually, and a comprehensive initial assessment and annual reassessment, the results of which are addressed in the enrollee's care and service plan. In addition, the SNP's model of care (MOC) would be evaluated annually to assess the degree to which its MOC goals were met, and each MOC element would have to meet a minimum benchmark to receive approval.

Recommendation: AHIP supports the proposed standardization of care management requirements across the three SNP types but with some modifications. First, while C-SNP and I-SNP enrollees can be expected to have higher than average levels of acuity, that is not the case with all D-SNP enrollees. When a plan's assessment of a D-SNP enrollee concludes that the enrollee has low acuity and few care needs, this would require only a minimal care plan and not warrant designation of an IDCT. We recommend that CMS revise the proposal to permit some level of plan discretion in this regard. Second, we recommend that the standardized care management requirements be voluntary for the first year, and that CMS engage with plans that voluntarily adopted the care management standardization to identify any problems and challenges with standardization before making the requirement mandatory. We also recommend that CMS refine its proposal in two areas:

- With respect to a D-SNP enrollee receiving managed long-term services and supports (MLTSS) through a Medicaid managed care plan, CMS should encourage the D-SNP IDCT to use best efforts to (i) obtain the enrollee's MLTSS assessment and care/service plan; and (ii) incorporate key MLTSS elements from those sources into the D-SNP MOC. This will help reduce the extent to which enrollees are subjected to duplicate assessments and redundant care planning processes.
- CMS should seek further input on the appropriate methodology to evaluate a D-SNP's success in meeting MOC goals and benchmark scoring. For example, the methodology should account for the effects of churn on MOC execution, as some dual eligibles experience changes in Medicaid eligibility that affects their SNP enrollment. In addition, with respect to full benefit dual eligibles, care management of a full benefit dual eligible enrollee would be more comprehensive and complex than for a partial dual eligible because it would take into account Medicaid benefits and possibly LTSS, which generally are not available to partial dual enrollees. We believe MOC evaluations and scoring should account equitably for the

distinct levels of care management engagement and execution in their application to D-SNPs with different mixes of full and partial dual eligibles.

E. Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes (§ 422.514)

CMS proposes to impose significant new restrictions on MA plans that are not D-SNPs but that have high proportions of Medicare-Medicaid dual eligible enrollment. CMS calls these plans "D-SNP look-alike" plans. CMS indicates that the plans' designs tend to attract dual eligible enrollees because they allocate a lower percentage of MA rebate dollars to reducing Medicare cost-sharing (which is paid for by Medicaid) and a higher percentage to supplemental benefits. CMS raises a number of concerns, including that such plans are not subject to the same integration requirements as D-SNPs.

Under the proposal, CMS would not enter into or renew a contract for plan year 2022 with an MA plan that is not a D-SNP in any state where there is a D-SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals, such as a Medicare-Medicaid plan (MMP), if certain dual eligible enrollment thresholds are met. Specifically, the MA plan is subject to the restriction for the following year if the proportion of dually eligible enrollment is either projected in its bid to be 80% or more, or the proportion of dually eligible enrollees actually enrolled in the plan in the January enrollment report of the current year is 80% or more. The actual enrollment prong would only apply to plans active for one or more years and with enrollment equal to or greater than 200. CMS also proposes to establish procedures for transitioning enrollees from D-SNP look-likes to other MA plans.

AHIP has been a strong supporter of enhanced integration of Medicare and Medicaid for dual eligibles and the continued evolution of integrated care delivery options. While we therefore appreciate CMS' goals in proposing the restrictions on look-alike plans, we have concerns with some of the assumptions underlying the proposal and potential unintended consequences.

1. Value of benefits and choices in look-alike options. We are concerned that the proposal does not adequately assess the negative impacts on enrollees who may lose access to plans they have determined best meet their needs. For example, CMS notes that "Most D-SNP look-alike enrollment is in markets that feature numerous other plan choices for beneficiaries." Rather than support CMS' proposal, we believe it suggests that people with Medicare and Medicaid who are enrolled in look-alike plans see value in those plans, even when other options are available.

Further, partial duals may see different value in look-alike plans as compared to full-benefit duals, but the proposal does not adequately assess those distinctions. For example, CMS' analysis about available options does not discuss the extent to which D-SNPs covering partial duals are available in the service areas in which look-alike plans are operating. Further, the preamble references an analysis[17] of D-SNP look-alike plans by MedPAC in its most recent report to Congress. On page 444, the MedPAC analysis states:

[17] "Promoting integration in dual eligible special needs plans"; Chapter 12, MedPAC Report to Congress, June 2019; accessed at http://www.medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0

> "…*for some partial-benefit dual eligibles, there may nonetheless be an advantage to enrolling in D-SNPs* because those plans are more likely than traditional MA plans to offer coverage of dental, hearing, vision, and transportation services. These additional benefits are particularly attractive to the subset of partial-benefit dual eligibles who have their Medicare cost-sharing covered by Medicaid." (emphasis added)

This reasoning would apply to look-alike plans as well; such plans can offer partial dual eligibles benefits that may otherwise be unavailable in other plans. CMS' proposal could eliminate these valuable options for a low-income population that has come to rely on them.

The proposal also does not assess the extent to which enrollees who would lose access to look-alike plans would revert to receiving their care and services through the fee-for-service (FFS) environment of Original Medicare. While D-SNPs may offer their dual eligible enrollees higher levels of care management and integration, all MA plans deliver important care management and coordination services, as well as supplemental benefits, not available in the Original Medicare program. These losses are not accounted for in the proposal.

D-SNP look-alike plans appear to be fulfilling a need for dual eligibles, including partial dual eligibles who do not have Medicaid benefits. While the integration available in D-SNPs is an important and valuable benefit, we are concerned that CMS fails to account for the possible loss of other important and valuable benefits. We believe these potential impacts on partial dual eligibles need to be considered before CMS finalizes the proposal.

Lastly, the Medicare program has a core principle of freedom of choice. Medicare beneficiaries choose whether to enroll in Original Medicare or in an MA plan. If they opt for an MA plan, they choose a plan with a mix of benefits, premiums, and cost-sharing best suited to their needs from among the available plans in their service area. MA beneficiaries who enroll in look-alike plans find something attractive in them and have actively chosen to enroll. We are concerned that CMS does not consider how choice itself is an important objective, nor the impacts of limiting choices for the affected population.

Recommendation: Unless and until CMS is able to address these concerns more clearly, CMS should permit look-alike plans to continue to operate as an option for Medicare beneficiaries to help ensure that enrollees of such plans continue to have access to the increased levels of care management and supplemental benefits in MA plans. However, if CMS intends to move forward with rulemaking on D-SNP look-alikes, CMS first should perform a more detailed analysis of available options and potential lost benefits caused by the proposal, including a separate assessment of impacts on full and partial dual eligibles, and publish that analysis for notice and comment. CMS should also explain how it has accounted for the value of choice in its proposal. Such information would help stakeholders understand the potential impacts of the proposal and provide more informed comments. Finally, in determining a compliance time frame, CMS should allow at least two years for dual eligible beneficiaries, MA plans, states, and other stakeholders to review policy options, and devise and implement viable alternatives to achieve compliance.

2. Market distortions. It is possible that the market dynamics of look-alike plans are driven in part by market distortions such as providers, insurance agents, and brokers steering enrollees into or away

from certain service delivery models, inappropriate or misleading marketing practices, or as a result of beneficiary and provider confusion. The proposed rule does not account for those considerations.

Recommendation: CMS should consider targeted measures that would directly address these specific kinds of distortions, rather than implementing broad restrictions on look-alike plans. For example, if patterns of agent/broker or provider steering are implicated, then CMS might consider instituting measures that would reinforce referral to products best suited to the beneficiary's needs. If misleading marketing practices are a root cause, CMS already has a significant body of regulations and program rules it can bring to bear, and we support the proposal to prohibit MA plans from marketing look-alike plans as if they were D-SNPs or are designed for dual eligibles. In addition, to the extent there are concerns with effective care management and coordination of care for full benefit dual eligibles enrolled in look-alike plans, CMS could also consider requiring such plans to notify the state or the appropriate Medicaid managed care plan of members' hospital and SNF admissions and discharges, similar to requirements placed on non-HIDE non-FIDE "care coordination" D-SNPs beginning in 2021.

3. Availability of alternatives. The proposed restrictions would apply to look-alike plans in *states* with other more integrated service delivery options. However, in many states – e.g., California, Florida, New York, Ohio, and Texas – D-SNPs, MMPs, and other integrated options are not available in all geographic areas. CMS 2020 SNP Landscape Source Files[18] indicate that 608 counties have no D-SNP available and another 406 counties have only one D-SNP option. Given that Medicare beneficiaries may only enroll in MA plans offered in their county of residence, the current proposal could eliminate an important option for a beneficiary who actually has no integrated option available where he or she lives. Moreover, as noted above, some integrated options might be available only to full benefit dual eligibles, but the proposal does not distinguish between them and partial duals. And in states like those noted above, neither D-SNPs, MMPs, nor other integrated options are available in all counties to any dual eligible individual who might want to enroll.

Recommendation: If CMS decides to impose restrictions on D-SNP look-alike plans, we recommend that CMS limit the proposal to plans operating in a *county* where there is a D-SNP or other integrated plan option. Similarly, we believe the 80% determination threshold would be workable, but given that many SNPs operate in multi-county service areas, we recommend that the threshold test should be applied at the county level as well. The final proposal should also account for the specific categories of dual eligibles (e.g., full benefit duals only vs. both full and partial benefit duals) that can enroll in available integrated options in a given county. This would ensure that the superior features of MA plans as compared with the traditional Medicare program, such as enhanced supplemental benefits and care management programs, would be available as options for all dual eligibles.

[18] Count of D-SNPs by county from 2020 SNP Landscape Source Files (v 10 15 19). Available online at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2020-SNP-Landscape-Source-Files-v-10-15-19.zip

III. Implementation of Several Opioid Provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act

A. Mandatory Drug Management Programs (DMPs) (§ 423.153)

Since 2019, Part D sponsors have been permitted to establish drug management programs (DMPs) for potentially at-risk beneficiaries (PARBs). If a beneficiary is determined to be at risk for misuse of prescription drugs a sponsor may limit access to opioids and benzodiazepines to selected prescribers or pharmacies or may create point of sale edits. In the Proposed Rule, CMS notes that the vast majority of sponsors have voluntarily enacted DMPs.[19] CMS is proposing to enact SUPPORT Act Section 2004, which requires sponsors to implement DMPs for plan years beginning January 2022.

Recommendation: We support CMS' efforts to curb the opioid crisis and as such, our member plans have often voluntarily implemented DMPs. We encourage CMS to review the detailed comments submitted by our member plans on specific elements of the proposed standards, e.g. requests for clarification around the identification of PARBs. Additionally, we recommend that CMS release any needed technical guidance related to implementation of mandatory DMPs and other SUPPORT Act provisions as early as possible.

E. Eligibility for Medication Therapy Management Programs (MTMPs) (§ 423.153)

In accordance with the SUPPORT Act Section 6103, CMS proposes that Part D plans would be required to furnish materials in their MTM programs regarding safe disposal of prescription drugs that are controlled substances. CMS specifically proposes that Part D sponsors would be required to provide this information as part of the comprehensive medication review (CMR) or through the quarterly targeted medication reviews (TMRs) or follow up.

Recommendation: We support providing information to beneficiaries in MTM programs on safe disposal of drugs. However, we recommend that CMS consider allowing plans to include the information in alternative documents, other than CMR and TMRs, including in the beneficiary enrollment letters. For example, plans may have difficulty reaching beneficiaries after enrollment if they have disenrolled from the plan for any reason, and it would be useful for plans to have more venues to provide this important information.

IV. Implementation of Certain Provisions of the 21st Century Cures Act

C. Exclusion of Kidney Acquisition Costs from Medicare Advantage (MA) Benchmarks (§§ 422.258 and 422.306)

Pursuant to Section 17006(b) of the 21st Century Cures Act, CMS must develop a methodology to exclude the cost of organ acquisition for kidney transplant from the MA benchmarks beginning in

[19] "…85.9 percent of Part D contracts in calendar year 2019 and 87.2 percent for calendar year 2020 adopted DMPs to address opioid overutilization among their enrollees. Thus, of about 49 million beneficiaries who were enrolled in the Medicare Part D program in 2019, about 48.5 million enrollees (99 percent) were covered under Part D contracts that offered a DMP already." 85 Fed. Reg. 9002, 9025 (Feb. 18, 2020).

2021, when these costs are covered by the FFS Medicare program. CMS describes this process at a high level in the Proposed Rule, but included a more detailed methodology for doing so in the MA 2021 Advance Notice.[20] Under its proposed methodology, CMS would use Medicare cost report data and FFS inpatient claims data to calculate kidney acquisition costs as a percent of total FFS costs at the county and state levels, and then apply these ratios to carve-out kidney acquisition costs from the MA county and state ESRD benchmarks.

We are concerned with the magnitude of the organ acquisition cost carve-out estimates. In the Proposed Rule, CMS estimates the FFS Medicare cost of kidney acquisition at $2.82 per-member per-month (PMPM) in 2021 – this equates to roughly 8% of the average premium for an MA plan with prescription drug coverage in 2020.[21] This estimate also appears to diverge from the estimates included in the MA 2021 Advance Notice, in which CMS estimates that the average impact would be $4 PMPM for MA county rates, up to a high of $20 PMPM. Separately, the average impact would be $36 PMPM for state ESRD rates, up to a high of $75 PMPM.

Wakely Consulting Group (Wakely) analyzed a 5% sample of FFS Medicare claims data from the Limited Data Set (LDS) over the period 2014 to 2018.[22] Wakely found that only 20 of the 82 counties with a kidney acquisition carve-out rate above 1.0% had *any* kidney transplants identifiable in the LDS claims data. This analysis for the top 10 counties by kidney acquisition carve-out rate, excluding Puerto Rico, is shown below.

State	County	Kidney Acquisition Cost Carve-Out Factor in Advance Notice	Total Kidney Transplants (2014-2018 LDS)
OREGON	COLUMBIA	2.79%	0
WISCONSIN	DANE	1.85%	6
LOUISIANA	PLAQUEMINES	1.85%	0
CALIFORNIA	SAN FRANCISCO	1.66%	3
LOUISIANA	ORLEANS	1.66%	7
MISSOURI	ST LOUIS CITY	1.64%	6
NORTH CAROLINA	ORANGE	1.60%	0
MINNESOTA	OLMSTED	1.52%	1
PENNSYLVANIA	MONTOUR	1.44%	1
MINNESOTA	DODGE	1.35%	0

These data also suggest there were only a total of 11,340 kidney transplants for FFS Medicare beneficiaries in 2017 – this figure is 26% lower than the estimate of 15,436 CMS provided in the Proposed Rule.

[20] CMS. Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part II. February 2020.
[21] Jacobson, G., Freed, M., Damico, A., Neuman, T. Medicare Advantage 2020 spotlight: First look. Kaiser Family Foundation. October 2019. Available online at: https://www.kff.org/report-section/medicare-advantage-2020-spotlight-first-look-data-note/
[22] Wakely Consulting Group. 2021 Medicare Advantage Advance Notice. March 2020. Available online at: https://www.ahip.org/2021-medicare-advantage-advance-notice/

Recommendation: Historically CMS has released detailed data with annual FFS Medicare proposed rules as well as (albeit to a lesser degree) the annual MA Advance Notice and Final Announcement.[23] We request that CMS release similar information to allow for appropriate notice-and-comment regarding the methodologies for the underlying cost and discharge data used to calculate the kidney acquisition costs in determining the carve-out factors, and to explain why the estimates in the Proposed Rule differ from those in the Advance Notice. Furthermore, we request the detailed data and analyses CMS relied on to determine that county-level data is credible for the purpose of determining the kidney acquisition cost carve-out rates but not credible to support the calculation of the ESRD benchmark rates.

V. Enhancements to the Part C and D Programs

A. Reinsurance Exceptions (§ 422.3)

CMS proposes to establish standards for MA plans using reinsurance to limit exposure to medical losses. Specifically, CMS would provide two options: stop loss coverage for costs that exceed $10,000 per member per year for basic benefits, or first dollar pro rata coverage that does not exceed the cost of purchasing stop loss coverage for medical expenses exceeding $10,000 per member per year.

Recommendation: AHIP applauds CMS for proposing to establish reinsurance standards for the MA program. Establishment of standards helps to provide needed certainty regarding permissible use of reinsurance. At the same time, we have concerns that the proposal does not accommodate other types of risk arrangements that plans can use to reduce costs and offer packages of benefits to meet the needs of Medicare beneficiaries. Therefore, we also suggest that CMS provide additional options that include reinsurance and other types of risk sharing arrangements, including those that allow a minimum percentage of first dollar coverage retained by the plan. This would allow plans further flexibility to find a financial product that would be helpful to deliver benefits to Medicare beneficiaries while still ensuring plans are taking on significant risk.

We also fully support CMS' proposed clarification of its interpretation of Section 1855(b) of the Act to consider parent organizations to be part of MA organizations for purposes of meeting the Act's full risk and reinsurance requirements. Section 1855(b) of the Act requires MA organizations to assume financial risk on a prospective basis for the provision of basic benefits furnished to MA enrollees subject to certain exceptions. In the Proposed Rule, CMS states that it "…wishes to clarify what we consider to be an MA organization for purposes of this statute and is proposing to broaden our interpretation to include parent organizations. The result of that would be to evaluate compliance with section 1855(b) of the Act and proposed §422.3 at the parent organization level, such that risk

[23] See, for example: FFS data, trends, and ratebook supporting data for the MA and Part D Advance Notice and Final Rate Announcement (available online at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents); and the data files supplementing the comment period for the Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2020 (available online at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-P).

sharing or allocations of losses and costs among wholly-owned subsidiaries would not be evaluated."[24]

We believe that CMS' clarification to include parent organizations of wholly owned MA organizations is consistent with the intent of the Act. As one of its financial requirements for MA organizations, Congress implemented Section 1855(b) to ensure MA organizations were able to cover the costs associated with providing beneficiaries with the services they were entitled to receive. Reinsurance and analog guarantees between MA organizations' and their parent organization are long standing routine arrangements that meet a core policy goal of the Medicare program, to safeguard payment of claims and by extension, the beneficiaries who generated those claims. Parent organizations of wholly owned MA organizations are not true third-party organizations for which there is no nexus with CMS. Indeed, an MA organization with a 100% reinsurance arrangement with a parent would still meet all coverage, payment, and program integrity rules and remains the responsible party to CMS while also allowing for efficiencies in administration of the benefit program and more solid protection against financial exposure from unexpected changes in health care costs. Accordingly, we support CMS' proposal to clarify its interpretation by considering the parent organization to be part of an MA organization for purposes of Section 1855(b) of the Act.

B. Out-of-Network Telehealth at Plan Option

CMS solicits comments on whether to extend current regulations, which allow MA plans to treat additional telehealth benefits (ATBs) provided by contracted providers as basic benefits, to also include non-contracted providers.

Recommendation: We support CMS permitting (but not requiring) all MA plan types, including PPOs, to offer ATBs through non-contracted providers and treat them as basic benefits under MA. In the wake of COVID-19, CMS expanded permissible coverage for telehealth under the MA program to ensure Medicare beneficiaries can receive telehealth services at home to avoid placing themselves at greater risk of the virus. We applaud CMS for providing this coverage flexibility and believe that expansion of the current telehealth policy to permit MA plans to cover telehealth services provided by out-of-network providers as basic benefits is also appropriate.

E. Medicare Advantage (MA) and Part D Prescription Drug Program Quality Rating System (§§ 422.162, 422.164, 422.166, 422.252, 423.182, 423.184, and 423.186)

CMS proposes changes to the MA and Part D Star Ratings program, beginning with the CY 2021 measurement period and the 2023 Star Ratings. We have the following specific comments and recommendations on the proposed changes and on current program requirements that CMS has not specifically proposed to change in the Proposed Rule.

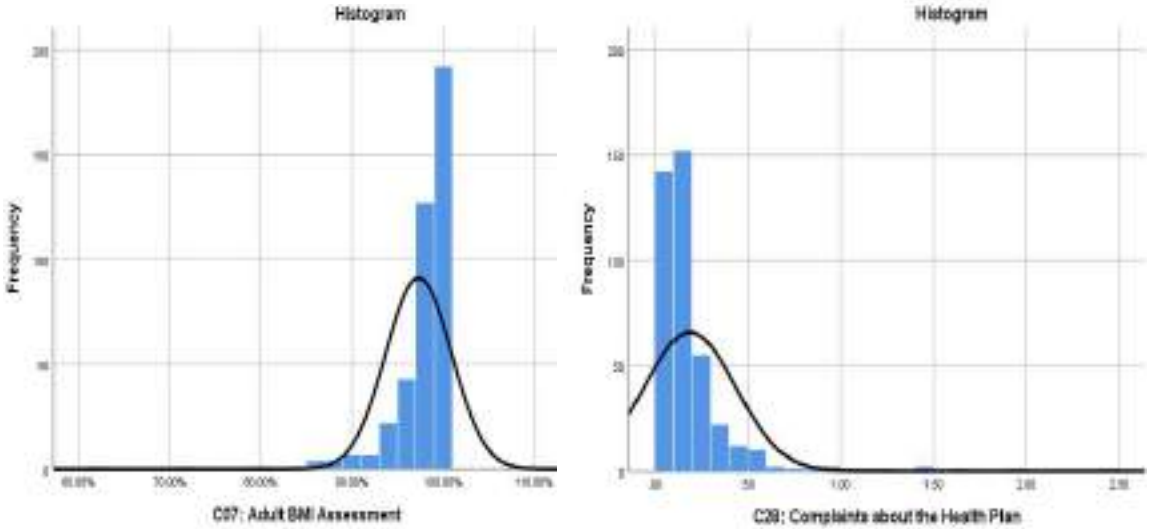
- **Cut point methodology**. For 2023 Star Ratings, CMS proposes to revise the cut point methodology for non-CAHPS measures by direct removal of observations considered Tukey

[24] 85 Fed. Reg. at 9041.

outliers.[25] CMS explains that its proposal would increase the stability and predictability of the non-CAHPS measure cut points. In its regulatory impact analysis, CMS further indicates that the proposed change to the cut point methodology would reduce Star Ratings for contracts and thereby reduce MA payments by $808.9 million for 2024, increasing to $1,449.2 million by 2030.[26]

There are many different statistical methodologies available to identify and address outlier observations. However, CMS has not explained why the agency specifically proposed the Tukey outlier methodology as compared to any of the other available methodologies. CMS has also not adequately defined what an 'outlier' is in the context of performance measurement for Star Ratings, including at what point in the measurement process outliers would be identified and excluded. Given the potential methodological flaws of this methodology – described in greater detail below – we believe the proposal is premature at this time and would require further analysis by statistical and measurement experts representing a range of stakeholders before being appropriately considered.

We have concerns that application of the Tukey outlier methodology in the Star Ratings program would be flawed. The Tukey outlier methodology is based on the assumption of a normal distribution of the underlying data[27]; however, many measures in the Star Ratings program have distributions with non-normal distributions, for example because they are significantly skewed in one direction. To illustrate this issue, in the charts below we show histograms of the Adult BMI Assessment and Complaints about the Health Plan scores by contract using 2020 Star Ratings data. The actual distributions of scores are represented in the blue bars, and standard normal distributions are imposed in black for comparison.



[25] Under the Tukey outlier methodology, observations that fall outside a range – in this case, 3 times the interquartile range – would be deemed outliers and removed from the values used to calculate the measure level cut points.
[26] 85 Fed. Reg. at 9044.
[27] Hubert, M., Vandervieren, E. An adjusted boxplot for skewed distributions. *Computational statistics & data analysis* 52(12): 5186-5201. August 2008.

These charts demonstrate the distribution of scores on the Adult BMI Assessment measure (a long-standing process measure from HEDIS) as well as the Complaints about the Health Plan measure (a CMS administrative measure based on the Complaints Tracking Module) are both highly skewed and therefore not normally distributed. Several other measures across data sources included in the Star Ratings program have non-normal distributions, making the Tukey outlier methodology inappropriate for those measures.

Additionally, the attached analysis by Wakely found that CMS may have significantly underestimated the adverse impact of this proposal on Star Ratings for plans.[28] Specifically, Wakely estimates that applying the Tukey outlier methodology in the calculation of cut points for 2023 Star Ratings would reduce MA spending by $1.4 billion. This would cut MA plan payments in just the first year by nearly 2 times more than CMS estimated. Nearly one-quarter of MA contracts would have their performance reduced by 0.5 Stars as a result of the methodology change.

Recommendation: AHIP opposes CMS' proposal. While we appreciate CMS' goal of increasing cut point stability and predictability, we continue to urge the agency to reinstate the policy that will best achieve those objectives: predetermined cut points in advance of the measurement period.

We believe the elimination of pre-determined thresholds has impeded CMS' goal of promoting continued quality improvement. Another recent analysis by Wakely (see attached) found significant year-over-year volatility in average Star Ratings for Patient Experience/Complaints and Access measures, despite consistent trends in plan performance over time.[29] Wakely concluded that year-over-year changes in the measure cut points drive this volatility and result in a "disconnect between contract performance and contract scores, or Star Ratings." To address this disconnect, Wakely suggests that "further study of the observed volatility and lack of correlation between performance and measure-level Star Ratings (based on current clustering methodology) is merited."

The retrospective clustering methodology CMS uses to establish measure cut points has also undermined the ability of plans and their providers to set markers for performance activities that are consistent with CMS' expectations. Moreover, as plans have transitioned to value-based arrangements with providers, setting goals is essential to help both parties assess the effectiveness of their efforts to improve quality of care and reduce costs while maintaining high performance and rating levels. MedPAC also supports prospectively set performance targets and has noted that retrospectively determined cut points make it "so plans cannot know in advance what outcomes they need to achieve, making it difficult for providers and plans to manage their quality improvement efforts."[30]

[28] Wakely Consulting Group. Proposed rule changes to the Medicare Star Rating program: Analyzing the impact of proposed changes on Medicare Advantage spending. March 2020.
[29] Wakely Consulting Group. Star Rating variability of patient experience and access measures: Analyzing the impact of variable Star Rating cut points and measure level results. March 2020.
[30] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. June 2019.

Set cut points in advance of the measurement period would also help to simplify the Star Ratings program and reduce burdens on providers contracting with multiple plans, who otherwise may face varying and conflicting quality performance metrics on the same quality measures. Predetermined cut points would thus promote a key Administration goal of reducing unnecessary regulatory burdens.

Further, we are concerned that CMS' proposed change to the cut point methodology, by reducing scores, would also adversely impact MA beneficiaries. MA plans with a Star Rating of at least 4 stars receive increased funding as an incentive to achieve high performance. Plans use these funds to provide additional benefits and reduce beneficiary cost-sharing. Changes to the Star Ratings program should support, not take away, these vital benefits.

Finally, we ask that CMS provide more details on its methodology so that plans can run similar simulations to better understand the impact of the proposed change to the cut points and plan ratings. For example, CMS does not clearly state: whether the impacts of mean resampling and guardrails, as codified in the 2020 Final Rule, were included in its impact analysis; if the analysis deviated at all from the published clustering methodology, what enrollment and revenue assumptions were used; and why CMS chose to model the impact on 2018 Star Ratings without taking into account other changes to the Star Ratings methodology finalized for 2021 and 2022 Star Ratings. For the reasons stated above, we oppose CMS' proposed change to the cut point methodology.

- **Weight increase of patient experience/complaints and access measures**. CMS proposes to increase the weight of patient experience/complaints and access measures from 2 to 4 for 2023 Star Ratings. This would result in the patient experience/complaints and access measures representing 52% of the overall Star Rating in 2023, an increase from 31% in the 2020 overall Star Rating. CMS assumes that with its proposal more contracts would experience increases in Star Ratings rather than decreases. Specifically, CMS indicates that the proposed change to the weights for these measures would result in an increase in plan payments of $391.4 million for 2024.

  We have serious concerns with this proposal.

  - An analysis by Wakely found that CMS may have overestimated the impact on Star Ratings for plans.[31] Specifically, Wakely, using 2020 Star Rating performance data (more recent than the 2018 data used by CMS), estimated that increasing the weights of patient experience/complaints and access measures in the 2023 Star Ratings would only increase MA plan payments by $83 million – nearly 5 times less than what CMS estimated. While this change would increase the overall Star Rating for some MA contracts, more MA enrollees are in plans that would be negatively impacted when the concurrent Tukey outlier proposed change is taken into account.
  - As noted above, Wakely also found that despite relatively consistent trends in plan performance over time, volatility in the cut points for these measures has created

[31] Wakely Consulting Group. Proposed rule changes to the Medicare Star Rating program: Analyzing the impact of proposed changes on Medicare Advantage spending. March 2020.

volatility and inconsistent trends in contract Star Ratings.[32] For example, average contract performance on the 2020 patient experience/complaints measures using the 2020 cut points resulted in an average Star Rating of 3.68, but this same level of performance would have resulted in an average Star Rating of 4.53 using the 2016 cut points. Wakely concludes that, "increasing the weights for these measures has the potential to erode the stability of the Star Ratings program – by basing the majority of the Star Rating score on measures that have historically shown significant Star Rating volatility despite relatively stable performance in measure level data."

- Weighting patient experience measures at 4 fails to account for the fact that the measures are based on a limited sample of beneficiaries and their experiences. Measures based solely on surveys and limited sampling may yield inaccurate, unreliable, or biased data. Extraordinary events, including the COVID-19 public health emergency, can also have significant impacts on patient experience/complaints and access.
- Increasing the weight of survey or administrative measures to 4 does not align with CMS' existing framework for measure categories, definitions and weights or its guiding principles for the program. CMS' guiding principles call for, among other things, that measures be developed by consensus-based organizations; that Star Ratings be a true reflection of plan quality and enrollee experience, treat contracts fairly and equally, and minimize unintended consequences; that data needed for measures be accurate, complete, and reliable; and that improvement on measures be under the plan's control. The existing measures framework also calls for outcome and intermediate outcome measures to be weighted at 3, a weight higher than other types of Stars measures (except for the improvement measures). We continue to support these guiding principles and believe it is critical that CMS use them as the framework for assessing weighting of measures for the program.
- The proposal also runs counter to the quality measurement principles of MedPAC, which establish the importance of outcome measures; MedPAC believes administrative measures should not be included at all in MA performance measurement, let alone be weighted the highest, as MA plans "should be held accountable for their insurance functions through compliance standards, not through" performance measurement.

Recommendation: We oppose increasing the weight of measures that are based solely on survey or administrative data to 4 and request that CMS not finalize the proposal. We also urge CMS to first provide more details on its methodology through formal notice and comment rulemaking. This will allow plans to run similar simulations to better understand the impact of the proposed change to the weighting for these measures and plan ratings, and thereby offer a more meaningful comment opportunity.

- **Part C Rheumatoid Arthritis Management measure**. CMS proposes to remove the Rheumatoid Arthritis Management measure from 2023 Star Ratings. CMS notes that NCQA is retiring this measure due to multiple reasons that would impact plan performance,

[32] Wakely Consulting Group. Star Rating variability of patient experience and access measures: Analyzing the impact of variable Star Rating cut points and measure level results. March 2020.

including concerns that members may receive anti-rheumatic drug therapy through Patient Assistance Programs, which do not generate claims.

Recommendation: We agree and support CMS' proposal.

- **Health Outcomes Survey (HOS) measures**. CMS proposes to make substantive changes to two HOS measures (Improving or Maintaining Physical Health and Improving or Maintaining Mental Health measures), including modifying the case-mix adjustment and increasing the minimum required denominator from 30 to 100 for 2023 Star Ratings. CMS indicates that increasing the sample size would help to improve the reliability for HOS measures.

  While increasing the sample size may be helpful in improving reliability of HOS measures relative to the current approach, we would continue to have significant concerns with the reliability even with such change. As we indicated in our comments in response to the Advance Notice for CY 2021, there is significant variability in plan performance year to year on HOS measures and research has identified reliability issues with patient reported outcome measures.[33] We are also concerned that performance on these measures is heavily influenced by factors beyond the care received by the patient, and there is limited evidence of the measures' responsiveness to health care interventions. We are also concerned that extraordinary events, including the COVID-19 public health emergency, could impact plan performance on HOS measures.

  Recommendation: Given the concerns about HOS measures noted above, we recommend that CMS focus on developing standards through notice and comment rulemaking for reliability of all Star Ratings measures, including HOS measures. As part of that effort, CMS should analyze and share its findings on the reliability of HOS measures and plan performance results.

  Furthermore, the proposed changes to the two HOS measures are substantive and therefore CMS should clarify in the final rule that they would be moved to the display page for 2023 and 2024 Star Ratings. In order for plans to also better assess reliability, we ask that CMS provide plans with access to inter-unit reliability data for the HOS measures (Improving or Maintaining Physical Health and Improving or Maintaining Mental Health measures), under the current and proposed new case mix methodology.

- **Part D Statin Use in Persons with Diabetes Measure.** The Part D Statin Use in Persons with Diabetes (SUPD) measure has a weight of 1 for 2020 Star Ratings. CMS decided to classify the measure as an intermediate outcome measure with a weight of 3 starting with 2021 Star Ratings in the 2019 MA and Part D final rule published in April 2018.[34] CMS is now proposing to reclassify the Part D SUPD measure as a process measure with a weight of 1 for 2023 Star Ratings because it "no longer believe[s] that is the appropriate

[33] https://www.rand.org/pubs/research_reports/RR1844.html
[34] 83 Fed. Reg. 16440 (April 16, 2018).

classification."[35] As we have previously commented, AHIP agrees that the Part D SUPD measure should be categorized as a process measure and receive a weight of 1 in Star Ratings. The measure developer, Pharmacy Quality Alliance (PQA), has also classified the measure as a process measure.[36]

Recommendation: We support CMS' proposed change to the weight and classification of this measure. However, we continue to recommend that the measure remain a process measure with a weight of 1, as it has been through 2020 Star Ratings (including for the improvement measure calculation). Under the proposal as written, the weighting would jump to 3 for 2021 and 2022 Star Ratings and then revert back again to a weighting of 1 for 2023 Star Ratings. This instability is not good for the Star Ratings program. While we commend CMS for adhering to the timing of changes as reflected in regulations, we believe the unique nature of this situation makes it appropriate for CMS to treat it as a technical correction that takes effect for 2021 Star Ratings.

- **Part C Transitions of Care Measure.** CMS proposes to add this measure to the Star Ratings in 2023 covering the 2021 measurement period. While we understand the importance of measuring transitions of care, we have raised several concerns and questions relating to data challenges and other issues affecting this display measure in our comments in response to the Advance Notice for CY 2021. For example:
    - Although NCQA has revised the "one medical record" requirement to support other communication forms, clarification is needed on how plans should indicate the use of other acceptable communication forms for this measure.
    - Communications from other types of providers that may support a beneficiary during a care transition should be counted. For example, communications from a health plan's case management system should be allowed under the Notification of Inpatient Admission and Receipt of Discharge Information indicators.
    - The changes to the measure will require additional training and changes to operations.
    - We understand that data collection challenges persist due to lack of interoperability of systems and facilities not having processes in place to provide notifications to the PCPs in a consistent and/or timely manner. These challenges may be exacerbated due to the impact of COVID-19 on health care providers and systems.
    - CMS does not provide information on how the changes to the Transitions of Care measure will impact the related Medication Reconciliation Post-Discharge Star Ratings measure.
    - NCQA's requirement that all four elements be completed may not appropriately account for variation of performance on the different elements.
    - Measure specifications do not account for cases that involve out-of-network providers, a fact pattern that can make aspects of the measure more challenging.

[35] 85 Fed. Reg. at 9046.
[36] https://www.pqaalliance.org/measures-overview#supd

Recommendation: We do not support the addition of this measure to the 2023 Star Ratings and ask that CMS keep this measure on the display page for 2023 Star Ratings (and possibly beyond) so that CMS can address the concerns we have raised, and organizations have sufficient time to understand, implement, and assess all proposed changes to this measure. Consistent with prior AHIP comments, we recommend that any new measure for Star Ratings should be fully tested and validated and material changes to a measure's specifications should be fully assessed prior to inclusion in Star Ratings.

- **Extreme and Uncontrollable Circumstances Policy**. In the Proposed Rule, CMS solicits feedback on its disaster relief policy, including for contracts impacted across multiple years.

  We continue to strongly believe that CMS should expand eligibility criteria under the disaster relief policy to cover more extreme and uncontrollable events (e.g., COVID-19 and other public health emergencies) that impact plan performance. Moreover, the policy should also be applied to all years affected by the event.

  For example, COVID-19 has affected the ability of MA and Part D plans to collect accurate data, and the ability of plans and their contracted providers to meet certain metrics for the 2019 and 2020 performance periods (2021 and 2022 Star Ratings). Travel bans, quarantines, and other related measures are limiting normal patient engagement activities and creating significant challenges in collecting certain types of data from providers, such as medical records. In addition, as hospitals, physicians, other providers and patients prioritize emergency functions over non-essential clinical care and administrative functions, enrollees are delaying or have difficulty accessing normally available and recommended preventive and other health care services. Moreover, public health recommendations on social distancing and a heightened level of uncertainty may lead to lack of physical activity, isolation, loneliness, and anxiety and thereby impact various quality and patient experience survey measures for all beneficiaries.

  We also note that CMS has provided significant quality reporting relief to providers in numerous FFS programs because of COVID-19.[37] CMS justified this decision based on the recognition, "that quality measure data collection and reporting for services furnished during this time period may not be reflective of their true level of performance on measures such as cost, readmissions and patient experience during this time of emergency and seeks to hold organizations harmless for not submitting data during this period."

  On March 31, CMS released an interim final rule with comment period (IFC) that includes modifications to the 2021 and 2022 MA and Part D Star Ratings.[38] In the IFC, CMS indicates that the changes the agency will make to the calculation of the 2021 and 2022 Star Ratings address the anticipated disruption to data collection and measure scores resulting from the COVID-19 pandemic. We support changes (and further adjustments if necessary) that ensure

[37] CMS Announces Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19 March 22, 2020, available online at https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting
[38] 85 Fed. Reg. 19230, https://www.govinfo.gov/content/pkg/FR-2020-04-06/pdf/2020-06990.pdf

plan ratings for 2021 and 2022 are not adversely impacted due to the COVID-19 pandemic. We will also provide these and other recommendations in response to the IFC.

Recommendation: We recommend that CMS make changes (and future adjustments if necessary) included in the IFC to ensure that plan ratings for 2021and 2022 are not negatively impacted due to COVID-19. Given the current exceptional circumstances, we also ask that CMS not apply the low performing icon to any plan for 2021 Star Ratings. In addition, CMS should consider a process allowing plans to demonstrate that absent COVID-19 they would have been able to receive higher Star Ratings. The agency should consider making adjustments to those impacted plans' ratings without adversely impacting other plans' ratings.

We also urge CMS to expand the eligibility criteria in its disaster relief policy to cover: disasters declared under a state or federal declaration, including a public health emergency such as COVID-19; other FEMA declarations, including those involving public or fire management assistance; and other uncontrollable circumstances such as drug recalls that cause significant disruptions to systems and access that would impact plan performance.

We also ask CMS to consider expanding its policy that covers contracts impacted by two different extreme and uncontrollable events in consecutive years to also include contracts impacted by a single disaster spanning multiple years. This would allow CMS' disaster relief policy to account for disasters, or other uncontrollable circumstances, that have longer lasting impacts or occur at the end of a coverage year.

Additionally, we understand that in some cases, the extreme and uncontrollable events methodology can actually reduce Star Ratings for certain plans impacted in two or more consecutive years. We believe this was never CMS' intention, and urge that no plan be adversely impacted under this policy. To eliminate adverse impacts on multi-year affected contracts, CMS should apply a longer look back period under its policy. CMS' policy should also ensure that non-affected contracts are not disadvantaged due to disaster-relief related Star Ratings adjustments.

Finally, CMS should review and update related sub-regulatory guidance (e.g., provisions in Chapters 2 and 4 of the Medicare Managed Care Manual and Chapters 3 and 5 of the Prescription Drug Benefit Manual) to ensure that CMS' guidance related to disaster relief is clear and consistent.

F. Permitting a Second, "Preferred", Specialty Tier in Part D (§§ 423.104, 423.560, and 423.578)

Currently, Part D sponsors can include a specialty tier for high-cost drugs in their plan designs. The Proposed Rule would allow sponsors to offer a second specialty tier, subject to certain conditions. The higher cost-sharing specialty tier would be subject to maximum allowable cost-sharing of between 25% and 33% (depending on the level of deductible), consistent with current rules. The second specialty tier would be a ''preferred'' tier that offers lower cost-sharing. Drugs on the higher-cost specialty tier would be subject to tiering exception requests to the preferred tier. However, plans could exempt drugs on either specialty tier from tiering exceptions to non-specialty tiers. In addition,

Part D sponsors would have flexibility in deciding which of the specialty tiers to place eligible high-cost drugs. The proposal would not specify any minimum required difference between the cost-sharing levels of the higher cost and preferred tiers. Finally, the Proposed Rule codifies current methodologies for establishing specialty tier thresholds and eligibility of particular drugs to be placed on the tiers, with some modifications that include basing determinations on ingredient cost rather than negotiated price and making adjustments in increments of not less than 10% rounded down to the nearest $10 based on an annual analysis of prescription drug event data.

Recommendation: AHIP has long advocated for permitting a preferred specialty tier in Part D. Accordingly, we strongly support CMS' proposal. We agree with CMS that a second specialty tier will improve the ability of Part D sponsors to negotiate larger discounts from drug manufacturers in exchange for preferred formulary placement and encourage Part D enrollees to use the most cost-effective drugs. We appreciate the Administration's repeated recognition of the importance of expanding private-sector negotiating tools, competition and choice, which leads to lower patient cost-sharing, reduced premiums, savings for plan customers like employers and states, and lower costs for taxpayers. The proposal is also consistent with a prior recommendation from MedPAC, which further noted the potential for two specialty tiers to encourage competition among drug manufacturers.[39]

In addition to supporting the overall policy, we want to acknowledge our support for various components of the proposal that offer flexibility in benefit design. Such provisions, individually and in combination, are important to achieving the goals of encouraging negotiation and cost-effective drugs, enhancing competition, and reducing costs. In particular:

- **Giving sponsors discretion in placement of drugs between specialty tiers**. We support CMS' proposal to give plans flexibility to determine which drugs will be placed on each specialty tier. This will enable plans to structure the benefit in a way that encourages enrollees to use the most cost-effective drugs.

  CMS requests input on an alternative approach that would limit the preferred tier to generics and biosimilars. We oppose such an approach. If implemented, the restriction would limit the ability of plans to negotiate the highest potential discounts from drug manufacturers. Moreover, high-priced generics are increasingly commonplace (see e.g., the table below showing average spending per claim for the top 10 most costly multisource generics in Part D in 2018). Moreover, generics and biosimilars are not always the lowest cost therapeutic alternative for a given condition. We also believe tiering based on drug cost, rather than exclusively based on labels like brand or generic, is a more meaningful approach for beneficiaries. Accordingly, we urge CMS to move forward with its proposed approach and not impose limits on tiering composition that can raise costs in the Part D program.

[39] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. June 2016.

Generic Name	Number of Manufacturers	Average Spending Per Claim
Bexarotene	4	$19,047.87
Flucytosine	5	$8,703.86
Phenoxybenzamine HCl	3	$7,883.81
Abiraterone Acetate	5	$7,346.42
Imatinib Mesylate	11	$5,581.19
Tetrabenazine	8	$4,451.16
Metformin HCl	5	$4,021.48
Azacitidine	7	$3,968.56
Dihydroergotamine Mesylate	3	$3,076.10
Tobramycin In 0.225% Sod Chlor	5	$2,719.61

Source: Medicare Part D Drug Spending Dashboard & Data.

- **Imposing a maximum cost-sharing based on the level of deductible.** We support CMS' proposal to allow higher cost-sharing on the specialty tier for plans with reduced or no deductible, consistent with current rules. The flexibility encourages competition and choice in benefit design, including plans with different deductible levels, thereby helping beneficiaries have access to options that best meet their needs. Moreover, even with the increased cost-sharing percentage, enrollees covered by drugs on the specialty tier can still pay considerably less than they would if the drugs were placed on a non-specialty tier with higher cost-sharing.

  Conversely, AHIP would oppose a change in rules that would impose a maximum 25% cost-sharing on the specialty tier regardless of whether there is a deductible. The agency solicits comments on such an approach, indicating it is unclear why the specialty tier should be differentiated from other tiers on the basis of the deductible. However, since its creation the specialty tier has been differentiated from other tiers in various ways. They include limiting the specialty tier to certain drugs based on cost; restricting the cost-sharing amount to the amount permitted under the defined standard benefit – either 25% with a standard deductible, or an actuarially equivalent amount with a reduced or no deductible; and exempting the specialty tier from tiering exceptions. Taken together, these provisions are designed to encourage lower cost-sharing for high cost drugs while minimizing cost-sharing and premium impacts throughout the benefit. If CMS eliminated the ability of plans to charge actuarially equivalent amounts for high cost drugs when deductibles are reduced, it would mean plans with reduced deductibles may need to raise costs for drugs on other tiers and/or increase premiums to achieve actuarial equivalence. Changing the cost-sharing rule therefore would be inconsistent with the steps the Administration has taken to enable Part D sponsors to increase choice and reduce costs and premiums for all seniors.

- **No required difference in cost-sharing between specialty tiers.** We support CMS' proposal to require no minimum differential between the two specialty tiers. As CMS notes, this approach encourages flexibility and recognizes the difficulty for CMS in anticipating

potential design variations. We also agree with CMS that "it would be unlikely that Part D sponsors would take the trouble to create two different tiers and then establish an inconsequential differential."[40] We commend CMS' practical approach of not creating an unnecessary regulatory restriction up front, while potentially reexamining the policy in the future based on actual experience.

- **Exemption from tiering exception to non-specialty tiers.** We support CMS' proposal to allow plans to exempt drugs on both specialty tiers from tiering exceptions to a non-specialty tier, consistent with the exemption that currently applies to the specialty tier. As CMS explains, the requirement that Part D sponsors offer a plan that is actuarially equivalent to the Defined Standard benefit might force Part D sponsors to increase premiums and cost-sharing for non-specialty drugs if Part D enrollees are able to obtain drugs on specialty tiers at any non-specialty tier cost-sharing that may be available. We agree that it is important for CMS to avoid such increased costs by continuing a policy that has been in place since the start of the Part D program. As CMS suggests, exempting specialty tier drugs from tiering exceptions to non-specialty tiers also improves Part D sponsors' ability to negotiate deeper discounts with manufacturers. We see no basis to modify the policy at a time when CMS is permitting a second specialty tier that could give enrollees access to even lower cost-sharing than the original specialty tier.

We also appreciate CMS' recognition in the preamble that permitting higher cost-sharing in the non-preferred tier compared to current rules can allow plans to negotiate even higher discounts for the preferred specialty tier, and could lead to lower premiums. We recommend that CMS continue to analyze this issue for future rulemaking.

G. Beneficiary Real Time Benefit Tool (RTBT) (§ 423.128)

CMS proposes to require that Part D plans develop a real time benefit tool (RTBT) that is patient-specific and includes formulary and benefit information by 2022. The proposal would require that the RTBT include accurate, timely, and clinically appropriate patient-specific real-time formulary and benefit information (including enrollee cost-sharing information, clinically appropriate formulary alternatives, and the formulary status of each drug presented including any utilization management requirements). To make the tool understandable to the average patient who typically does not have a clinical background, and to account for complexities in assessing alternatives for some drugs or drug classes/categories (such as drugs with significant side effects), the proposal would allow plans to use P&T committees to omit drugs in clinically appropriate circumstances from the beneficiary RTBT, even though those drugs may be required in the prescriber RTBT (which plans must implement by January 1, 2021[41]). The proposal would allow plans to add the tool to an existing beneficiary portal, create a new patient portal for this purpose, or enable beneficiaries to access the RTBT through a computer or smart phone application. Plans would also be required to make this information available to enrollees via their customer service call center. Plans would be encouraged but not required to include pharmacy-specific cost-sharing information and negotiated prices in the

[40] 85 Fed. Reg. at 9055.
[41] Modernizing Part D and Medicare Advantage To Lower Drug Prices and Reduce Out-of-Pocket Expenses, 84 Fed. Reg. 23834, 23847 et seq. (May 23, 2019).

beneficiary RTBTs. Lastly, the proposal allows plans to offer rewards and incentives to enrollees who use the tool subject to certain conditions.

Recommendation: We support the proposal, including elements that would provide flexibility on information plans are required to offer through the tool, such as exclusion of certain drugs and not requiring disclosure of negotiated prices. We also support CMS providing flexibility in how plans offer the RTBT. In addition, we support CMS' proposal to allow plans to encourage use of the tool through rewards and incentives.

However, we recommend that CMS make the 2022 effective date voluntary, with a mandatory effective date of 2023. The prescriber tool has not yet been introduced and prescribers will need time to become fully acquainted before beneficiaries can discuss these tools with them. Furthermore, plans currently developing prescriber tools will need to consider making appropriate changes to the existing tool for beneficiary use. This process will take time and resources, particularly if plans limit information based on clinically appropriate determinations by their P&T committees and implement additional beneficiary focused modifications (e.g., use of plain language). Additionally, CMS should provide as much flexibility as possible for plans to determine how to display formulary alternatives in a manner that is most practical and useful for beneficiaries.

We also note that plans are currently under enormous pressures relating to technology projects, including the need to implement and do likely follow-up work relating to the prescriber RTBT; activities required to implement the recently-released final interoperability rule; and the broad range of issues affecting plans in connection with the COVID-19 public health emergency. A voluntary 2022 effective date for those plans able to meet it, with a longer period for others, is needed to provide plans with sufficient time to develop, test and refine these tools and to educate their network providers and enrollees about their availability and use.

I. Medical Loss Ratio (MLR) (§§ 422.2420, 422.2440, and 423.2440)

CMS proposes to allow incurred claims in the MLR numerator to include amounts paid to non-providers for covered services, which would also cover the expanded supplemental benefits now available for MA plans.

Recommendation: AHIP strongly supports this MLR proposal. This approach would provide clarity about how plans should report these amounts and encourages MA plans to offer supplemental benefits to better address social barriers to care and other needs of MA enrollees.

J. Dismissal and Withdrawal of Medicare Part C Organization Determination and Reconsideration and Part D Coverage Determination and Redetermination Requests (§§ 422.568, 422.570, 422.582, 422.584, 422.590, 422.592, 422.631, 422.633, 423.568, 423.570, 423.582, 423.584, and 423.600)

CMS proposes to establish processes for the withdrawal or dismissal of: Part C organization determination and reconsideration requests, Part D coverage determination and redetermination requests, and Part C and Part D independent review entity (IRE) reconsiderations.

Recommendation: AHIP recommends that CMS ensure that the final regulatory requirements are not more restrictive than current CMS guidance. For example, CMS' proposal indicates that only a timely written request can be used to withdraw a request whereas current CMS guidance indicates that verbal notifications are also acceptable.[42] CMS should continue to permit verbal withdrawal requests. For clarity, we also recommend that CMS structure the Part C and Part D regulatory text the same way where possible. For example, in §422.584 (Expediting certain reconsiderations) CMS repeats the rules from a different section while §423.584 (Expediting certain redeterminations) cross refers to them. These minor distinctions can generate questions and confusion and should be eliminated when possible.

VI. Codifying Existing Part C and D Program Policy

A. Maximum Out-of-Pocket (MOOP) Limits for Medicare Parts A and B Services (§§ 422.100 and 422.101)

Unlike the traditional Medicare program, MA plans are required under current regulations to implement an annual MOOP limit for all enrollees. CMS sets two MOOP limits each year: 1) a "mandatory" MOOP representing the maximum limit a plan can impose, estimated as the out-of-pocket costs incurred at the 95th percentile of projected traditional Medicare beneficiary spending; and 2) a "voluntary" MOOP, estimated as the out-of-pocket costs incurred at the 85th percentile of projected traditional Medicare beneficiary spending. In 2020, the mandatory MOOP limit is $6,700 and the voluntary MOOP limit is $3,400. Plans offered at the voluntary MOOP limit or below are provided additional flexibility in benefit design.

Beginning in 2022, CMS is proposing three changes to the regulations governing how the MOOP limit for MA plans is determined: 1) establishing explicit authority for the agency to set up to three MOOP limits, 2) codifying the methodology for setting the MOOP limits, and 3) adjusting the methodology for setting the MOOP limits to take into account the removal of restrictions on beneficiaries with ESRD being allowed to enroll in MA plans beginning in 2021. Through these proposals, CMS would create a new third MOOP limit – referred to in the Proposed Rule as the "intermediate" MOOP limit – set in-between the existing mandatory MOOP limit and the "lower" (renamed from "voluntary") MOOP limit. In addition, CMS would phase-in additional costs incurred by beneficiaries with ESRD into the MOOP limit calculation over time.

AHIP supports the new intermediate MOOP. In addition, we strongly support CMS taking the "ESRD cost differential" – or difference between projected traditional Medicare beneficiary out-of-pocket spending including vs. excluding beneficiaries with ESRD – into account in setting the MOOP limits. However, we have concerns with the complexity and potential length of the phase-in schedule proposed by CMS. We also note that while necessary, these changes to the rules around plan benefit design as proposed may increase costs for all beneficiaries and will not fully address longstanding concerns regarding the adequacy of MA payment rates for beneficiaries with ESRD.

[42] https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf

In the CY 2021 Part C Benefits Review and Evaluation (Part C bidding instructions), CMS proposed to partially incorporate traditional Medicare claims costs for ESRD beneficiaries into the calculation of the MOOP limits, which would increase the MOOP by an additional $400. Specifically, CMS chose to incorporate 40% of the ESRD cost differential. In the Proposed Rule, CMS proposes to increase that percentage by 20 percentages points each year, with guardrails to limit any year-over-year increases beyond a certain amount, until the ESRD cost differential is fully reflected in 2024 or later. However, CMS projects that 50% of the beneficiaries with ESRD anticipated to enroll in MA by 2026 will enroll in 2021.

While we have questions about whether CMS' projection understates actual enrollment, in response to the 2021 Part C bidding instructions we recommended that CMS at a minimum reflect its full estimate and therefore incorporate 50% of the costs of ESRD enrollees in the MOOP limit calculation (rather than 40%) for 2021. In addition, we are concerned that CMS' proposal to mitigate significant year-over-year increases in the MOOP limits by phasing in the ESRD cost differential is overly complex and may be difficult for plans to project for business planning purposes.

Recommendation: To increase transparency as well as predictability, we recommend that CMS simplify the methodology for incorporating the remainder of the ESRD cost differential over time. For example, CMS could phase-in the remainder of ESRD cost differential at a fixed rate of 25% percentage points annually through 2023 as follows: 50% in 2021, 75% in 2022, and 100% in 2023.

CMS also seeks comment on whether to codify a rule requiring the agency to issue sub-regulatory guidance applying the MOOP limit methodology each year.

Recommendation: We support CMS in codifying a rule that requires the agency to issue sub-regulatory guidance applying this methodology each year. The annual deadline for issuing this guidance should align with the schedule for issuing the Advance Notice of Methodological Changes (i.e., no later than 60 days prior to the first Monday in April with a minimum 30-day comment period).

B. Service Category Cost-sharing Limits for Medicare Parts A and B Services and Per Member Per Month Actuarial Equivalence Cost-sharing (§§ 422.100 and 422.113)

In addition to an annual MOOP limit, CMS imposes limits on plan cost-sharing for individual services. These limits are intended to ensure cost-sharing is the same or lower (on an actuarially equivalent basis) to the traditional Medicare program as well as to protect beneficiaries against potential discriminatory benefit designs.

In the Proposed Rule, CMS has proposed to codify its current policies and methodology for interpreting and applying limits on MA cost-sharing for basic benefits, including flexibility for plans applying a MOOP below the maximum limit, with some modifications. These modifications include how the service-specific limits will be set for plans implementing the new intermediate MOOP limit, how the limits apply to copayments, and additional requirements regarding how comparisons between MA plan and traditional Medicare cost-sharing are conducted to ensure the benefits are at least equivalent on an actuarial basis.

Consistent with the MOOP limits, in the Proposed Rule and in the CY 2021 Part C bidding instructions CMS is proposing to incorporate 40% of the ESRD cost differential into the calculation of the service-specific PMPM cost-sharing limit for inpatient hospital acute and psychiatric services for 2021.[43] This percentage would increase to 60% in 2022, 80% in 2023, and 100% in 2024. In our response to the Part C bidding instructions, we recommended that CMS incorporate 50% of the ESRD cost differential in 2021 to align with OACT's enrollment projections.

Recommendation: We recommend that CMS use the same schedule for incorporating the ESRD cost differential in the inpatient hospital acute and psychiatric services as the MOOP limits – we offer the example above of 50% in 2021, 75% in 2022, and 100% in 2023. In addition, we recommend CMS release the methodology used for setting these cost-sharing limits in sub-regulatory guidance each year consistent with guidance on the MOOP limit methodology.

C. Plan Crosswalks for Medicare Advantage (MA) Plans and Cost Plans (§§ 417.496 and 422.530)

CMS proposes to codify the current process and conditions for plan crosswalks. Additionally, CMS proposes to codify the rules for crosswalk exceptions, including permissible D-SNP to D-SNP crosswalks.

Recommendation: In order to minimize administrative and regulatory burdens, we recommend that CMS classify permissible SNP to SNP crosswalks exceptions as permissible plan crosswalks. We also recommend that the SNP organization not be required to provide enrollees transitioned from one SNP to another with an Annual Notice of Change (ANOC) if there are no substantive changes in enrollee premiums, benefits, and cost-sharing as a result of the transition.

E. Medicare Advantage (MA) and Cost Plan Network Adequacy (§§ 417.416 and 422.116)

General

CMS proposes to codify the existing network adequacy standards with several modifications. The agency proposes to reduce the percentage of beneficiaries required within specified time and distance standards in rural areas; provide a 10 percentage point credit towards meeting time and distance standards for certain specialty types when the plan contracts with telehealth providers for those specialties; and provide a 10 percentage point credit toward the percentage of beneficiaries residing within time and distance standards for affected provider and facility types in states with certificate of need (CON) laws or other anti-competitive restrictions.

Recommendation: We support CMS's proposed changes that enhance network adequacy flexibility. However, we also request that CMS consider expanding that flexibility in several ways:

- **Telehealth.** The COVID-19 pandemic has reinforced how critical it is from a public policy perspective to encourage the widespread availability of telehealth services. To further

[43] Note that based on an analysis by OACT, CMS does not estimate that incorporating costs for traditional Medicare beneficiaries with ESRD into the calculations will affect other service-specific cost-sharing limits and therefore does not propose a transition schedule for changing the methodology as it relates to these other services.

encourage its growth, the agency should expand the specialty types eligible for the telehealth network credit to include, at a minimum, allergy and immunology, nephrology, ophthalmology, and primary care. We also believe CMS should consider for future rulemaking a more wide-ranging reassessment of the established time and distance standards given the rapid growth of telehealth technology and the potential for easier access and lower costs.

- **Rural.** While we appreciate the reduction of beneficiaries in rural areas who must be within time and distance standards and we support 85%, we encourage CMS to analyze the impact of a further reduction (for example 80%) in future rulemaking, including whether a lower number would impact MA penetration. Furthermore, we encourage CMS to streamline the network exception request process by considering ways to minimize reporting burdens associated with resubmissions of previously approved requests.

We support these additional flexibilities for CY 2021. For plans to be able to adjust their networks appropriately, CMS should release additional guidance and updated health service delivery (or HSD) tables as soon as possible before bids are due. We also ask that CMS and health plans work together to consider additional flexibilities in standards in states that have CON laws; and modify the exceptions criteria and process in ways that reduce burden, improve consistent reviews, and reflect the changing healthcare landscape.

Dialysis Services

CMS seeks comment on proposals to enhance current network adequacy requirements around the provision of dialysis services in order to reduce costs, improve quality, and increase beneficiary convenience and quality of life. The outpatient dialysis market is highly concentrated, with two companies currently controlling nearly 75% of dialysis services available to Medicare beneficiaries.[44] Recent research has found that, while overall beneficiary outcomes – as measured by hospital days and mortality – have improved over time, outcomes in independently owned facilities acquired by these two companies were negatively impacted after acquisition.[45] These results are a "cautionary tale" and raise concerns about the role of consolidation in the dialysis industry.[46] Consolidation in the dialysis market has also lead to significantly higher prices – for one large dialysis provider, commercial insurers paid an average rate per treatment four times higher than government programs in 2017.[47]

[44] Analysis of CMS Medicare Dialysis Facility Compare - Listing by Facility data. Last updated on January 22, 2020. Available online at: https://data.medicare.gov/Dialysis-Facility-Compare/Dialysis-Facility-Compare-Listing-by-Facility/23ew-n7w9
[45] Erickson, K.F., Zhao, B., Niu, J., et al. Association of hospitalization and mortality among patients initiating dialysis with hemodialysis facility ownership and acquisitions. *JAMA Network Open* 2(5):e193987. May 2019.
[46] Wang, V., Maciejewski, M.L. Patient outcomes and dialysis consolidation—Two big to fail? *JAMA Network Open* 2(5):e193962. May 2019.
[47] Childers, C.P., Dworsky, J.Q., Kominski, G. et al. A Comparison of payments to a for-profit dialysis firm from government and commercial insurers. *JAMA Internal Medicine* 179(8):1136–1138. May 2019.

As Secretary Azar has aptly noted, "88 percent of Americans with ESRD start treatment with center-based dialysis. Just 12 percent start treatment at home with hemodialysis or peritoneal dialysis. This is the complete opposite of the situation in some of our peer nations, including Hong Kong, where more than 80 percent of patients benefit from some form of in-home dialysis. Improving this situation dramatically, as we ought to do, will mean examining the payment incentives in our programs today, while expanding access to new technologies."[48] Moreover, CMS has acknowledged that home dialysis is often preferred over facility-based dialysis by both patients and providers. The ESRD Treatment Choices payment model is being implemented in traditional Medicare to reverse this trend by overhauling the delivery of kidney care. Expansion of home dialysis and other alternative delivery methods is all the more important during the COVID-19 public health emergency: people with serious illness and/or a compromised immune system are more vulnerable to the spread of coronavirus, and need to have a viable treatment infrastructure that allows them to access life-saving dialysis services while protecting them from exposure to infection.

AHIP appreciates and strongly supports CMS enacting policies in the MA program to enhance network contracting options to promote innovation, increase access, and reduce costs for beneficiaries with ESRD who choose to enroll in MA plans. MA plans are already developing and employing new ways to improve health and outcomes for beneficiaries with ESRD, including the initial expansion of home dialysis to individuals for whom it is clinically appropriate; new value-based care models to incentivize the delivery of higher-quality, evidence-based care; and new home hemodialysis devices being piloted in clinical trials to bring them to market as early as possible. We believe advancements in dialysis technology and the expansion of options for providing dialysis treatment at home are near a tipping point, and that the modifications to network adequacy requirements are greatly needed for MA plans to deliver on the goals articulated in the Administration's Advancing American Kidney Health Initiative.

Recommendation: We strongly support CMS implementing two of the changes to MA plan network adequacy requirements for dialysis services that the agency identified: 1) removing outpatient dialysis from the list of facility types for which MA plans need to meet time and distance standards, and 2) allowing plans to attest to providing medically necessary dialysis services in its contract application instead of requiring each MA plan to meet time and distance standards for providers of these services. These changes would be consistent with how CMS monitors and ensures MA beneficiary access to durable medical equipment, home health care, and transplant services. By allowing MA plans to attest they are providing medically necessary dialysis services in their contract applications, CMS will ensure patient protection while also giving plans the flexibility they need to expand the delivery of innovative solutions to beneficiaries with ESRD requiring dialysis treatment. This is especially critical at a time when enrollment of beneficiaries with ESRD is expected to rapidly increase and is reinforced by the need to identify alternatives to facility-based care as a result of the COVID-19 crisis.

[48] Alex M. Azar II, "Remarks to the National Kidney Foundation," March 4, 2019. Available online at: https://www.hhs.gov/about/leadership/secretary/speeches/2019-speeches/remarks-to-the-national-kidney-foundation.html

F. Supplemental Benefit Requirements (§§ 422.100 and 422.102)

CMS proposes to codify prior sub-regulatory guidance on primarily health related supplemental benefits and uniform benefit flexibility.

Recommendation: We strongly support the codification of these provisions. We also recommend that CMS update relevant Medicare managed care manual chapters to include the revised policies and to provide examples of permissible benefits to promote common understanding and clarity.

G. Rewards and Incentives Program Regulations for Part C Enrollees (§ 422.134 and Subpart V)

CMS proposes to modify and clarify certain components of regulatory standards for the Part C Rewards and Incentives program.

Recommendation: AHIP strongly supports the use of rewards and incentives to encourage MA enrollees to be actively engaged in their health care and improve overall health and well-being. That is why we also continue to urge CMS to expand the rewards and incentives program to Part D benefits. We commend the step CMS is taking in the Proposed Rule to allow rewards and incentives for the use of the beneficiary real-time benefit tool. A broader availability of rewards and incentives in Part D could help to increase engagement between Part D plans and their enrollees and to improve enrollees understanding of Part D benefits, out-of-pocket costs, and clinically appropriate coverage alternatives.

H. Requirements for Medicare Communications and Marketing (§§ 422.2260 – 422.2274; 423.2260 – 423.2274)

CMS proposes to codify in regulation the guidance contained in the Medicare Communications and Marketing Guidance (MCMG). In the preamble, CMS indicates that with this codification, the agency intends "for the proposed regulations to closely mirror [] long-standing sub-regulatory guidance." We appreciate CMS explaining its intention. However, we and our member plans have identified several discrepancies between the MCMG and the proposed regulatory text. For example, the proposed regulatory text states that "[w]hen a MA organization includes its customer service number, the hours of operation must be included the first time (at a minimum) the number appears," in general communication materials. However, CMS' August 6, 2019 guidance on the MCMG updates for CY 2020 deleted Subsection 30.4 that included the required display of hours of operation in materials.[49]

Recommendation: We recommend that CMS closely review feedback it receives on the proposed regulatory text to ensure that the final regulatory text aligns with language in the current MCMG. Consistent with CMS' intention, the final regulatory text should also not impose any new restrictions on marketing or impose new marketing requirements that are not included in the current MCMG. We also ask that CMS provide the final marketing guidelines and related model documents soon after

[49] https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Medicare_Communications_and_Marketing_Guidelines_Update_Memo_-_8-6-19.pdf

release of the final Rate notice and include a specific date for the release of marketing guidance and related materials in the agency's annual MA and Part D calendar (e.g., early May). The release date for marketing guidance and model materials is an important factor and has a direct impact on plan operations and development of beneficiary materials.

I. Past Performance (§§ 422.502 and 423.503)

CMS proposes criteria the agency will use in determining whether to deny an MA or Part D application based on past contract performance. This proposal would replace the past performance review methodology. Specifically, CMS proposes to adopt three factors, each of which would be a basis for CMS to deny an application: 1) the imposition of civil money penalties (CMPs) or intermediate sanctions, 2) low Star Ratings scores, and 3) the failure to maintain a fiscally sound operation.

Recommendation: We do not support CMS' proposal for several reasons. Although we appreciate efforts to simplify past performance reviews, CMS' proposal would be too restrictive, raises equitable concerns, and necessitates more clarity and transparency. For example, low Star Ratings scores could be the result of events not under the control of the plan such as the possible impact of COVID-19. CMS should, therefore, not consider low Star Ratings as a determining factor to deny applications, including service area expansions. It is also important to keep in mind that audits that can trigger CMPs are not applied uniformly to all plans during the same period. As such, this proposal raises equitable concerns. More clarity is also needed regarding the CMP amount that would result in an application denial. CMS' proposal also does not indicate whether the agency would consider mitigating factors (e.g., implementation or completion of a corrective action plan) and provide plans with a remediation opportunity and an appeals process as part of its plan performance review, which we strongly recommend. In light of the number of concerns and questions raised above, we urge CMS not to finalize its proposal on past performance at this time.

www.wakely.com

Proposed Rule Changes to the Medicare Star Rating Program

Analyzing the Impact of Proposed Changes on Medicare Advantage Spending

America's Health Insurance Plans

March 20, 2020

Developed by:
Wakely Consulting Group, LLC

Suzanna-Grace Sayre, FSA, MAAA, CERA
Senior Consulting Actuary

Dani Cronick, FSA, MAAA
Consulting Actuary

Table of Contents

Executive Summary 2
Introduction and Background 4
Comparison of CMS and Wakely Methodologies 5
Summary of Key Findings 7
Conclusion and Key Takeaways 11
Disclosures and Limitations 11
Appendix 1 – Finalized 2021 and 2022 Star Rating Changes 13
Appendix 2 – Methodology and Key Assumptions 14

Executive Summary

Wakely conducted a high-level analysis of the Star Rating program changes outlined in the Contract Year 2021 and 2022 Medicare Advantage and Part D Proposed Rule[1] issued by the Centers for Medicare & Medicaid Services (CMS). This report includes estimates of the impact that the proposed changes in the Proposed Rule would have on Medicare Advantage Organizations' (MAO) Overall Star Ratings, and the resulting impact to Medicare Advantage (MA) spending. If adopted, the 2023 Star Rating changes will impact MA spending in the 2024 payment year. The proposed changes were each viewed in isolation as well as combined. While the report goes into greater depth, below are the key finding from this analysis:

Increasing Patient Experience/Complaints and Access Measure Weights from 2.0 to 4.0 would increase MA Spending by less than the CMS estimate.

If this proposed change had been implemented for the 2020 Star Ratings, the change would be an increase to 2024 MA spending of $83.0 million, or $0.30 per member per month (pmpm), resulting in net cost to CMS. This value is far lower than the change of $391.4 million that CMS estimated in the Proposed Rule. The approach we used to estimate this change matches the CMS methodology, with a few key differences.[2] The valuation of this change does not include consideration of other Star Rating changes, and we did not incorporate the addition, removal, or weight changes of other measures that will occur prior to the change in Patient Experience and Access Measures.

Deleting Tukey Outliers from the Clustering Methodology would decrease MA Spending by more than the CMS estimate.

After incorporating the impact of mean resampling and cut point guardrails to the 2020 Star Ratings (a finalized change to go into effect in the 2022 Star Ratings), the incremental impact of Tukey outlier deletion would be a decrease to 2024 MA spending of $1.4 billion, or $5.24 pmpm, resulting in additional net savings to CMS. This value is significantly larger than the net savings of $808.9 million estimated by CMS in the Proposed Rule. As with the change in Patient Experience/Complaints and Access measure weights, this estimate is based on Wakely's interpretation of CMS's methodology. Other than mean resampling and cut point guardrails, this estimate does not incorporate other finalized Star Rating changes.

[1] https://www.govinfo.gov/content/pkg/FR-2020-02-18/pdf/2020-02085.pdf

[2] There may be several differences between the CMS and Wakely valuations, including but not limited to: a different base Star Rating year used to estimate the change (CMS used 2018, Wakely used 2020) and differences in 2024 enrollment and spending projections. Further detail around CMS and Wakely methodology and assumptions is included later in the report.

The combined Star Rating System Changes would decrease MA Spending by more than the CMS estimate.

After combining the two proposed Star Rating changes described above, the resulting impact is a decrease to 2024 MA spending of $1.1 billion, or approximately $4.10 PMPM[3]. This is a significantly larger figure than the net savings of $417.5 million estimated by CMS in the Proposed Rule, and a significantly higher cost to the MAOs. Based on our analysis methodology, which considers the composite impact of the expected methodological changes to be implemented by 2024 payment year, it is possible that CMS has materially understated the impact to MA plan sponsors. While we acknowledge that the order of operations may influence component impact estimates, the aggregate estimated impact of proposed changes published in the Proposed Rule is materially lower than Wakely's estimate.

As noted above, these estimates differ significantly from those published in the Proposed Rule. We attempted to match the CMS methodology in our estimates wherever possible. Table 1 summarizes the differences in these estimates. Note that the combined impact is less than the sum of the two proposed changes. When combined with the increase in Patient Experience and Access measure weights, the impact of Tukey outlier deletion is dampened as these measures become a smaller portion of weighting in the Overall Star Rating calculation.

Table 1 – Differences in the Estimated Impact of Proposed Star Rating Changes

	Impact to 2024 Medicare Advantage Spending	
Proposed Change	CMS Estimate	Wakely Estimate
Increasing Measure Weights	$391.4 million	$83.0 million
Tukey Outlier Deletion	$(808.9) million	$(1,443.8) million
Combined Impact	$(417.5) million	$(1,130.5) billion

CMS has not provided enough information on methodology and assumptions for other parties to independently validate or recreate the results.

There are several areas where CMS does not provide clarity on the methodology used to estimate the impact of these changes. A description of the items that are missing or unclear is included below in this report.

[3] The combined estimate also includes the impact of Mean Resampling and cut-point guardrails on the 2020 Star Ratings.

Introduction and Background

America's Health Insurance Plans (AHIP) retained Wakely Consulting Group, LLC (Wakely), to review the impact of the Star Rating changes in the Contract Year 2021 and 2022 Medicare Advantage and Part D Policy and Technical Changes to the Medicare Advantage Program (hereafter referred to as the "Proposed Rule"), issued by the Centers for Medicare & Medicaid Services (CMS) on February 18, 2020[4]. If finalized, CMS estimates that the proposed changes will result in an estimated $4.4 billion in savings to the federal government over ten years. The majority of these savings arise from changes to the MA and Part D Quality Star Rating system.

The CMS Star Rating system was introduced in 2008 and began impacting MAO spending in 2012. The system is designed to measure two major components of Medicare Advantage (MA) and Prescription Drug Plans (PDPs): 1) the quality of health and drug services received by beneficiaries, and 2) the experiences of enrolled beneficiaries. Over the past few years, CMS has implemented several changes to the Star Rating system with the goal of improving accuracy and stability. Appendix 1 contains a summary of the finalized changes that will take effect in the 2021 and 2022 Star Rating years.

If adopted, the 2023 Star Rating changes described in the Proposed Rule would impact MA spending in the 2024 payment year. The changes include:

- **Increasing Patient Experience/Complaints and Access Measure Weights from 2.0 to 4.0.** This change represents an additional increase beyond the change finalized in the April 2018 rule, which increased the weights of these measures from 1.5 to 2.0. The majority of these measures are CAHPS surveys of health plan members. CAHPS surveys focus on the quality of care from the perspective of patients, such as access to care and care coordination issues. The increase in measure weights will impact the calculation of the overall and summary Star Ratings, not the measure-level Star Rating assignment.
- **Deleting Tukey Outliers from the Clustering Methodology**. As part of an ongoing effort to increase predictability and stability of the Star Rating system, CMS has proposed Tukey outer fence outlier deletion[5]. If implemented, the Tukey method will represent an additional step to the clustering methodology, to be applied prior to the application of mean resampling and five (5) percent guardrails. Removing contracts with outlier measure scores from the clustering methodology will impact the assignment of Star Ratings at the measure level as well as the calculation of the overall and summary Star Ratings.

[4] https://www.cms.gov/newsroom/fact-sheets/contract-year-2021-and-2022-medicare-advantage-and-part-d-proposed-rule-cms-4190-p-1

[5] The Tukey Outer Fence method flags observations outside of a range calculated as a multiple of the interquartile range, and designates these observations as "outliers". CMS has proposed a multiple of 3.0 to identify outlier data points.

- **Remove the Rheumatoid Arthritis Management measure.** The National Committee for Quality Assurance (NCQA) is retiring this measure from the HEDIS measurement set for 2021 due to multiple concerns that the performance on the measure may not reflect the rate at which members get anti-rheumatic drug therapy. The removal of this measure will impact the calculation of the overall and summary Star Ratings.

Comparison of CMS and Wakely Methodologies

Wakely attempted to match the methodology used by CMS to estimate the changes described in the Proposed Rule throughout this analysis, with a few key differences. Table 2 describes both known and unknown differences in data, methodology, and assumptions between Wakely estimates and the methods described by CMS in the Proposed Rule. These differences should be carefully considered before comparing Wakely and CMS estimates.

Table 2 – Key Differences in CMS and Wakely Methodologies

Method/Assumption	CMS	Wakely	Potential Impact on Results
Mean Resampling and Guardrails Consideration for mean resampling and guardrails in the estimate of the proposed Tukey outlier deletion change	**Unclear** CMS proposes to amend the outlier definition to apply Tukey outlier deletion prior to mean resampling and guardrails, which were already finalized in the 2019 Final Rule[6].The estimate of Tukey outlier deletion does not clearly state whether the impact of mean resampling and guardrails is included.	**Yes** Wakely applied mean resampling and guardrails to the 2020 Star Rating cut points prior to applying Tukey outlier deletion, therefore the estimate of the Tukey outlier deletion impact does not include the impact of mean resampling and guardrails.	**High** Star Rating program changes have compounding impacts on results. Consideration for measure level changes set to occur would alter results.
Deviation from Published Clustering Methodology	**Unclear** For several of the 2020 Stars measures, it does not	**Published CMS Cut Points** Wakely used the published cut points	**Medium** The Wakely estimate of Tukey outlier impacts may be

[6] https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf

Method/Assumption	CMS	Wakely	Potential Impact on Results
	appear that CMS uses the methodology published in the Star Ratings Technical Notes. These measures include C14, C29, C31, D04, and D09[7].	for these measures without any adjustments.	understated because we do not consider any changes to the cut point for these measures.
Enrollment and Revenue Growth Assumptions	**Unclear** CMS only notes that the United States Per Capita Cost (USPCC) growth rates and county-specific quality bonus payments were used.	**Wakely 2024 Benchmark Rate Projections** No explicit Enrollment Growth assumed vs. 2020 enrollment Revenue growth assumptions include consideration of benchmark growth, future ACA caps, and current 2020 county-level contract enrollment.	**Medium**
Base Data Cut Points Estimation of Star measure cut points on the base data, without considering any changes from the Proposed Rule	**Stars Measure Data for All Contracts**	**Stars Measure Data for Published Contracts Only** CMS does not publish measure data for all contracts, therefore it is not possible for Wakely to match the published cut points exactly.	**Low** Wakely normalized the results to account for the difference in derived cut points.

[7] C14 - Diabetes Care – Kidney Disease Monitoring, C29 - Members Choosing to Leave the Health Plan, C31 - Plan Makes Timely Decisions about Appeals, D04 - Complaints about the Drug Plan, D09 - MPF Price Accuracy

Method/Assumption	CMS	Wakely	Potential Impact on Results
Star Rating Data Data used for the analysis of Tukey outlier deletion, mean resampling, and guardrails	**2018 Star Rating Data**	**2020 Star Rating Data** Wakely utilized the most recent Star Rating Data that is publicly available.	**Unknown** Wakely did not test the impact of the difference in Star Rating data.

Summary of Key Findings

Other than the known deviations described above, we attempted to replicate the logic CMS used to support estimations in the Proposed Rule. For a full description of our methodology and assumptions, see Appendix B. The following scenarios were tested in the order described below:

Recalculated 2020 Star Ratings Cut Points Using the Public CMS Measure Data Set

It is not possible to replicate CMS's cut point calculations exactly because CMS excludes some contracts' Stars measure data from the published data set. To evaluate the impact of each Star Rating program change, we first ran the clustering methodology on the published 2019 and 2020 Star Rating measure data. This gave us slightly different results than the published 2019 and 2020 cut points. We used the new set of cut points in each subsequent step of Star Rating changes. This step was necessary to ensure that all subsequent changes to cut points determined using the published data – guardrails, mean resampling, and Tukey outlier deletion – were capturing only the impact of the Star Rating change, and not the impact of the difference between published Star Rating cut points and our calculations on the limited public data set. After applying the recalculated cut points, the total estimated 2024 MA spending changed by -0.4%. We then applied a contract-level adjustment to bring each contract back to its published Overall Star Rating for 2020. This method of normalization resulted in a set of contracts with the same contract-level and total 2024 estimated revenue as that which is implied by the published 2020 Star Ratings.

Applied 2023 Star Rating Changes Described in the Proposed Rule.

- **Increasing Patient Experience/Complaints and Access Measure Weights from 2.0 to 4.0.** There are currently 11 Part C measures and 7 Part D measures in the 2020 Star Ratings that are classified as Patient Experience/Complaints or Access measures. These measures are currently 33% of the Overall MA-PD Star Rating

weights. In the 2021 Star Rating year, these measure weights will change from 1.5 to 2.0, bringing their total weight to 40%. If implemented, changing the weight of these measures from 2.0 to 4.0 in the 2023 Star Ratings will bring these measure weights to 53% of the Overall MA-PD Star Rating.

If this change were implemented for the 2020 Star Ratings, without applying any other proposed 2021 and 2022 Star Rating changes, 16.5 percent of MA–PD contracts and 9.5 percent of members would have seen their Star Rating increase by 0.5 Stars, and 2.5 percent of contracts, as well as 3.9 percent of members, would decrease by 0.5 Stars. The net impact of these Star Rating changes is an increase of $83.0 million (+$0.30 pmpm) in estimated 2024 MA spending. As CMS mentioned in the proposed rule, this increase in MAO spending is due to plans more commonly performing more favorably on these measures.

- **Tukey Outlier Deletion**. Tukey outlier deletion removes data points that are deemed "outliers" from the data set before running the CMS clustering methodology. Because there are typically more low outliers than high outliers, this change would increase cut points and decrease measure-level Star ratings for many contracts.

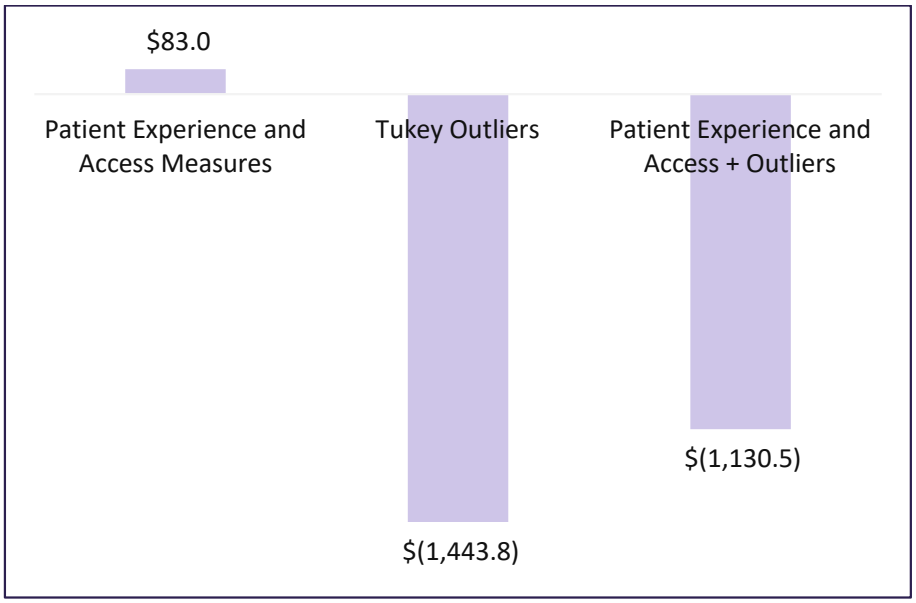
  If this change were implemented for the 2020 Star Ratings, without applying any other proposed 2021 and 2022 Star Rating changes, 3.3 percent of MA–PD contracts and 11.9 percent of members would have seen their Star Rating increase by half a star, while 18.7 percent of contracts and 17.3 percent of members would have decreased by half a star. The net impact of these Star Rating changes is a decrease of $1.4 billion (-$5.24 pmpm) in estimated 2024 MA spending.

Combined All 2023 Star Rating Proposed Changes.

The proposed Tukey outlier deletion change impacts various measures differently – specifically, this change would decrease non-CAHPS Star Ratings but would not have an impact on the CAHPS measures, many of which are also Patient Experience and Access measures. The result is an offsetting impact when these two changes are applied all together versus individually.

Figure 1 below shows the dollar impact that each Star Rating change is anticipated to have on MA spending, as well as the combined impact of both changes. Positive values indicate an increase in MA spending and additional costs for CMS. Negative values indicate a decrease in total MA Spending due to a particular Star Rating change, driving net savings for CMS.

Figure 1 – Proposed Rule Changes, Impact to MA Spending
Shown in millions

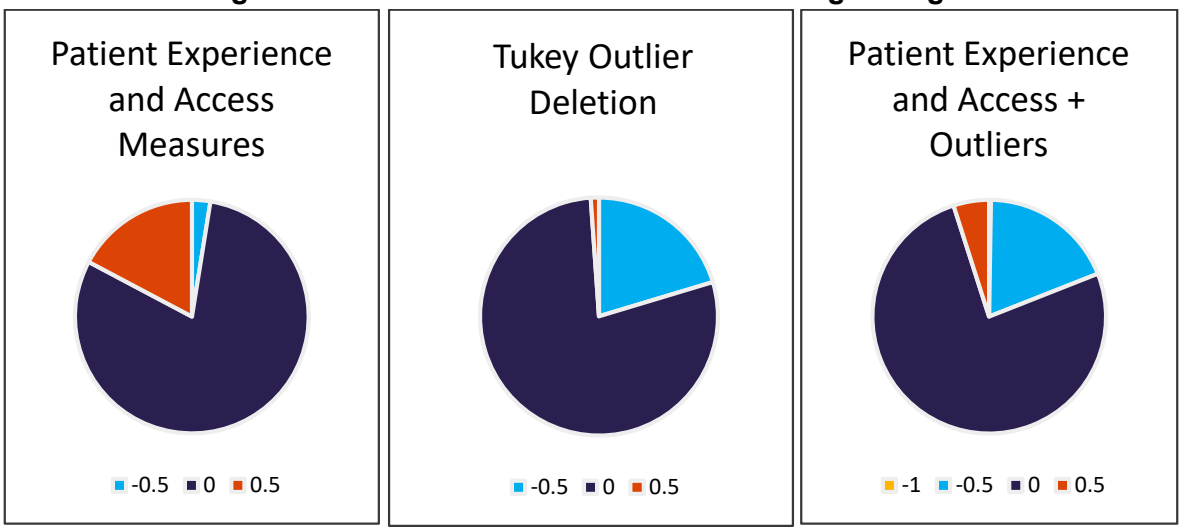


The combined impact of the Proposed Rule is a lower level of savings for CMS than if each change was evaluated separately. There is an offsetting impact between the change in cut-point methodology impacting all non-CAHPS measures and the increase in weight for Patient Experience and Access measures, many of which are CAHPS measures.

Figure 2 on the following page shows the distribution of contracts that improved 0.5 Stars, deteriorated by 0.5 Stars, deteriorated a full Star[8], or stayed constant (0) under each proposed Star Rating change.

[8] There was one contract that deteriorated a full star after the impact of both Patient Experience and Access Measures changing weight and Tukey Outliers being removed from the cutpoints.

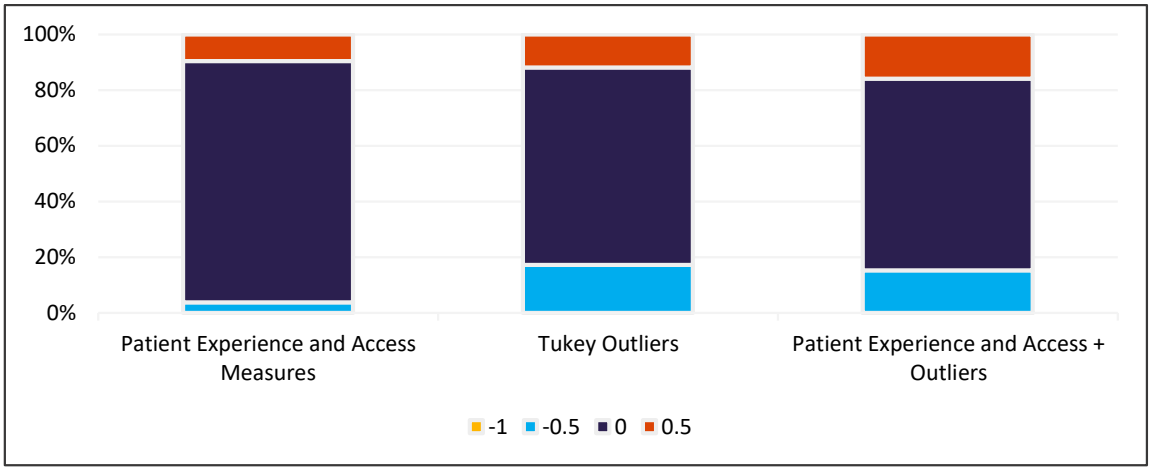
Figure 2 – Distribution of Contract Star Rating Changes



Note that the change in weighting for Patient Experience and Access Measures is favorable for more MAO contracts than it is unfavorable. On the other hand, almost a quarter of contracts will see a decrease in Star Ratings with the Tukey outlier change.

Figure 3 shows the distribution of members impacted by either an increase in half a star (0.5), a decrease in half a star (-0.5), a decrease in a full star (-1.0)[9], or members who were not impacted (0). Overall, between the two changes more members are expected to be impacted by a decrease in contract Star Rating than an increase.

Figure 3 – Distribution of Star Rating Changes, Member Weighted



[9] Although it is not visible in Figure 2 or Figure 3, one contract with just over 2,000 members decreases by a full star after considering the impact of the Patient Experience and Access Measures and Tukey outlier deletion changes.

Conclusion and Key Takeaways

Although the Wakely and CMS results differ due to known and unknown differences in methodology, our analysis suggests that the CMS quantification methodology may underestimate the negative impact of the Star Rating changes in the Proposed Rule.

CMS has not provided enough information on methodology and assumptions for other parties to independently validate or recreate the results.

There are several areas where CMS does not provide clarity on the methodology used to estimate the impact of these changes. In addition, CMS has estimated the impact of the proposed changes using an older data set (2018 Star Ratings), without updating for more recent MA plan sponsor performance in the Stars program. In order for stakeholders to fully understand and validate the impact to the Star Rating program, we respectfully request that CMS provide further documentation supporting the methodology for determining the published estimates in the Proposed Rule. In addition, we ask that CMS consider updating this analysis to use more recent Star Ratings data.

CMS estimates in the Proposed Rule may underestimate the negative impact on MA spending of proposed changes to the Star Ratings program, potentially significantly.

As illustrated throughout the report, the anticipated increase in MA plan sponsor spending driven by Patient Experience and Access measure changes is expected to be less than the CMS estimate, and the anticipated decrease in MA plan sponsor spending from the Tukey outlier deletion change is expected to be materially greater than the CMS estimate. In total, vs. the Wakely methodology, CMS may have understated the expected impact on MA plan sponsor spending in 2024 by more than $700 million.

Disclosures and Limitations

Responsible Actuary Suzanna-Grace Sayre and Dani Cronick are the actuaries responsible for this communication. They are both Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the sole use of the America's Health Insurance Plans (AHIP) and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. We acknowledge that AHIP may provide the report to their

participating health plans. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their actuarial experts in interpreting results. This information is confidential and proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this analysis are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. **Actual results may vary, potentially materially, from our estimates.** Wakely does not warrant or guarantee the projected values included in the analysis. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest We are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent to AHIP.

Data and Reliance We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Subsequent Events There are no known relevant events subsequent to the date of information received that would impact the results of this analysis. Differences or updates in the assumed contracts or risk and utilization of populations may cause deviation in results.

Deviations from ASOPS Wakely completed the analysis using sound actuarial practice. To the best of my knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations.

Appendix 1 – Finalized 2021 and 2022 Star Rating Changes

2021 Finalized Star Rating Program Changes

- Plan All Cause Readmission (Part C) to be temporarily removed while the measure is being updated
- All Patient Experience and Access Measures (Part C) to increase in weight from 1.5 to 2.0
- Recalculation of the Categorical Adjustment Index[10] (CAI) based on the latest plan performance data

2022 Finalized Star Rating Program Changes

- Adult BMI Assessment (Part C) to be removed
- Controlling Blood Pressure (Part C) to return to the Stars Calculation with a weight of 1.0
- Appeals Auto forward (Part D) to be removed – this is an Access measure that would have increased in weight for 2023 Star Ratings if it were not removed
- Appeals Upheld (Part D) to be removed – this is an Access measure that would have increased in weight for 2023 Star Ratings if it were not removed
- Cut point calculations to be updated with the additional process of mean resampling and adding 5% cut point guardrails

[10] The Categorical Adjustment Index is intended to adjust contract level Star Ratings based on level of Low Income and Disabled enrollment in the contract.

Appendix 2 – Methodology and Key Assumptions

Methodology Overview

Wakely used the published 2019 and 2020 Star Ratings Data Tables[11] to evaluate the impact that specific changes to the Medicare Star Rating Program and calculations would have to Medicare Advantage Organizations (MAOs). These tables include measure level data (ex. a contract scoring 83% on the Breast Cancer Screenings measure), measure level Star Ratings (ex. a contract receiving 4 stars out of 5 on the Breast Cancer Screenings measure), Part C and D cut points for each measure, and Overall Star Ratings. We then replicated the CMS calculations for the 2019 and 2020 Overall Star Ratings for every contract by calculating raw Overall Star Ratings (weighting each measure with the CMS defined measure weight) and then adjusting for Part C and D Improvement Measures, Reward Factors, and the Categorical Adjustment Index (CAI).

With all contracts aligning in their starting point – Calendar Year 2020 Overall Star Rating – each of the changes in the Proposed Rule could be evaluated separately as well as together.

Recalculating 2020 Star Rating Cut Points Using Public CMS Measure Data Sets

Wakely ran the clustering methodology on the published Star Rating measure data set to develop a new set of cut points for each Stars measure. Only the Stars measures that use clustering methodology were updated. All CAHPS measures use the relative distribution and significance testing methodology. There are no proposed changes to the relative distribution and significance testing methodology in the Proposed Rule, so Wakely used the published Star Ratings for these measures with no changes.

After developing a new set of cut points for each non-CAHPS measure, the results were then compared to the published 2019 and 2020 Star Rating cut points and checked for reasonability. For the majority of Stars measures, the new cut points were relatively unchanged from the publish cut points. However, there were several measures with large cut point differences: Diabetes Care – Kidney Disease Monitoring, Members Choosing to Leave the Plan, Timely Decisions and Appeals, Complaints About the Drug Plan, MPF Pricing Accuracy, and the Part C and Part D Health Plan Quality Improvement measures. Wakely used the published cut-points for these measures without any adjustments.

To estimate the impact of recalculating cut points using published data, Wakely recalculated the Overall Star Ratings for every available contract using the revised 2020 Star Rating cut points.

[11] https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData

Next, all contracts were identified with changing Star Ratings between the published cut points and the simulated Wakely cut points. 20 percent of contracts had an Overall Star Rating decrease by half a star. For these contracts, half a star was added in order to adjust the Wakely base 2020 Star Ratings to match the published Star Ratings. This adjustment was also made in each subsequent change to the Star Rating program. After making these adjustments, the resulting data set was normalized to remove the impact of using cut points recalculated from the published data set.

Mean Resampling and Guardrails

Wakely simulated the mean resampling and guardrail methods as described in the 2019 Final Rule to all of the non-CAHPS measures in the 2020 Star Ratings data set. The mean resampling and guardrail methods could have an effect not only on the current Star Ratings year but also on subsequent years. We accounted for this by simulating mean resampling on the 2019 Star Ratings data. The resulting cut points served as the reference point for applying the guardrail to the cut points obtained through applying both mean resampling and guardrails to the 2020 Star Ratings data. The 2020 Star Rating thresholds with mean resampling and a 5 percent guardrail were then simulated by referencing the simulated 2019 Star Rating cut points. The 5 percent guardrails were applied to all measures in the Part C and D Star Ratings program.

Patient Experience and Access Measures

In the 2021 Star Rating year, CMS will increase the weight of all Patient Experience and Complaints Measures as well as the weight of all Access Measures from 1.5 to 2.0. Under the Proposed Rule, CMS would again increase these weights further from 2.0 to 4.0 in the 2023 Star Rating year.

In order to calculate the impact of Proposed Rule change, Wakely recalculated the Overall Star Ratings for every available contract using the revised weights of 4.0. Note that the change currently being proposed and evaluated is a weight change from 2.0 to 4.0, since the change from 1.5 to 2.0 has already been codified. The changing weights also impacted the calculated reward factor for all contracts. Reward factors were recalculated to reflect the change in weights; however, the impact that these changing weights would have on the Part C and Part D Improvement Measure was not considered for this analysis.

Tukey Fence Outlier Exclusion

To improve stability in measure cut points over time, CMS has proposed to remove outliers using the Tukey Fence Outlier logic. This is a standard statistical method that identifies data points more than 3.0 times away from the outer quartiles. Values identified through Tukey outer fence

outlier deletion were then removed prior to mean resampling, and then clustering and the guardrails were applied.

To model this change, the clustering methodology was repeated after excluding any data-points identified as Tukey outliers and applying mean resampling. The change in cut points due to the outlier methodology was then applied to the current 2020 Star Rating cut points to establish new "Outlier" cut points, and guardrails were applied to limit the change between 2019 and 2020. Next, measure level data for all contracts and all non-CAHPS measures were compared to the cut points before and after the outlier exclusion and Overall Star Ratings were calculated.

One main simplification was made in this process. With the outlier changes, the Part C and Part D improvement measures would change based on changes to measure level Star Ratings. For this analysis, it was assumed that improvement measures would stay the same regardless of cut point changes.

Revenue Impact

The above methodologies describe how changes in Overall Star Ratings were determined for all contracts based on the CMS proposed changes. The last step in the analysis was to quantify the resulting financial impact of these changes. Table B1 demonstrates the impact that Star Ratings have on MAO plan benchmarks and rebate percentages.

Table B1: Quality Bonus and Rebate Percentages by Star Rating

Plan Rating	*Bonus Payment*	*Quality Bonus Adjusted Benchmark*	*Rebate Percentage*
5.0	*5.0%*	*105% of Benchmark*	*70%*
4.5	*5.0%*	*105% of Benchmark*	*70%*
4.0	*5.0%*	*105% of Benchmark*	*65%*
3.5	*0.0%*	*100% of Benchmark*	*65%*
3.0	*0.0%*	*100% of Benchmark*	*50%*
New Plans under New MAOs	*3.5%*	*103.5% of Benchmark*	*65%*
Plans Not Reporting	*0.0%*	*100% of Benchmark*	*50%*

To quantify this impact, first Individual county-level benchmarks for 2021 through 2024[12] were determined for every 2020 contract at each Star Rating from 1.0 to 5.0. This involved utilizing

[12] Contract level benchmarks beyond 2020 assumed a constant county level enrollment distribution from 2020 forward.

published February 2020 county-level enrollment and Wakely internal county benchmark projections based on the known quartile changes, ACA benchmark caps, and current CMS benchmark projections. A bid estimate was derived for each Star Rating by applying an estimated bid to benchmark ratio to the contract level benchmark. The bid to benchmark ratios was developed at the county, product, and SNP type-level based on historic publicly available bids and benchmarks and trends in bid to benchmark ratios by quartile. Using this established bid and benchmark, the resulting MA revenue was then determined for all individual plans at each Star Rating.

Because Employer Group Waiver Plans (EGWP) do not submit a bid, the revenue for these plans at each Star Rating was determined by the EGWP payment rate. The revenue impact of a change in Star Rating, therefore, is based on the change in the payment rates based on Star Ratings.

Finally, the quantified revenue impact was multiplied by the estimated contract risk score. Risk scores were developed from 2017 publicly available data at the county, product, and SNP type level and were applied to the contract based on their enrollment distribution at the county, product, and SNP type level.

www.wakely.com

Star Rating Variability of Patient Experience and Access Measures

Analyzing the Impact of Variable Star Rating Cut Points and Measure Level Results

America's Health Insurance Plans

April 3, 2020

Developed by:
Wakely Consulting Group, LLC

Suzanna-Grace Sayre, FSA, MAAA, CERA
Senior Consulting Actuary

Dani Cronick, FSA, MAAA
Consulting Actuary

Wakely

Table of Contents

Executive Summary 2
Introduction and Background 4
Summary of Key Findings 6
Conclusion and Key Takeaways 10
Disclosures and Limitations 11
Appendix A – Methodology and Key Assumptions 13
Appendix B – Measure Level Results 15

Executive Summary

Wakely performed an analysis evaluating changes in measure level cut points over time and the resulting impact on Star Ratings for Medicare Advantage Organizations (MAOs). The focus of this report is Patient Experience and Complaints measures as well as Access Measures. The Centers for Medicare & Medicaid Services (CMS) will increase the weight of these measures from 1.5 to 2.0 for the 2021 Star Ratings. In addition, CMS has proposed a further increase in these measure weights to 4.0 in the Contract Year 2021 and 2022 Medicare Advantage and Part D Proposed Rule.[1] If implemented, these measures will have the largest weighting in the Overall Star Rating calculation. Below are the key findings from this analysis:

Although measure level data and performance has been relatively stable for Patient Experience/Complaints and Access measures, measure-level Star Ratings have been volatile.

After comparing average contract measure performance and Star Ratings, we determined contract Star Ratings are volatile year-over-year even while contracts have steadily improved in average measure values. This observation is particularly notable for Access Measures. The year-over-year change in cut points contributes to the observed volatility, and results in a disconnect between contract performance and contract scores, or Star Ratings.

Increasing the weight of Patient Experience/Complaints and Access measures could introduce greater instability to the Overall Star Ratings.

Our findings suggest that increasing the weights of the Patient Experience/Complaint and Access measures[2] will result in Star Ratings that are increasingly based on a set of measures for which there is evidence of material year-over-year volatility. The correlation between average contract performance and Star Ratings for these measures is unclear. Further study of the observed volatility and lack of correlation between performance and measure-level Star Ratings (based on current clustering methodology) is merited.

Figures 1 and 2 below demonstrate the volatility of these measures and disconnect between performance and ratings. All average results presented below are weighted equally across all contracts in order to be consistent with the weighting CMS uses in the clustering methodology. In other words, contracts are not weighted based on contract enrollment.

---

[1] https://www.federalregister.gov/documents/2020/02/18/2020-02085/medicare-and-medicaid-programs-contract-year-2021-and-2022-policy-and-technical-changes-to-the

[2] Throughout this paper, D02: Appeals Auto-Forward and D03: Appeals Upheld have been removed from summarized results because they will be removed from the Star Rating system beginning in 2022.

Figure 1
Patient Experience/Complaints Measures[3]

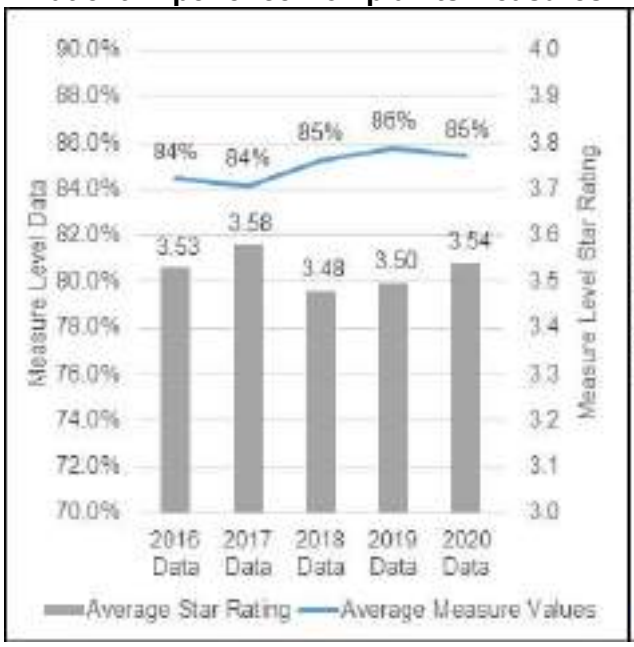
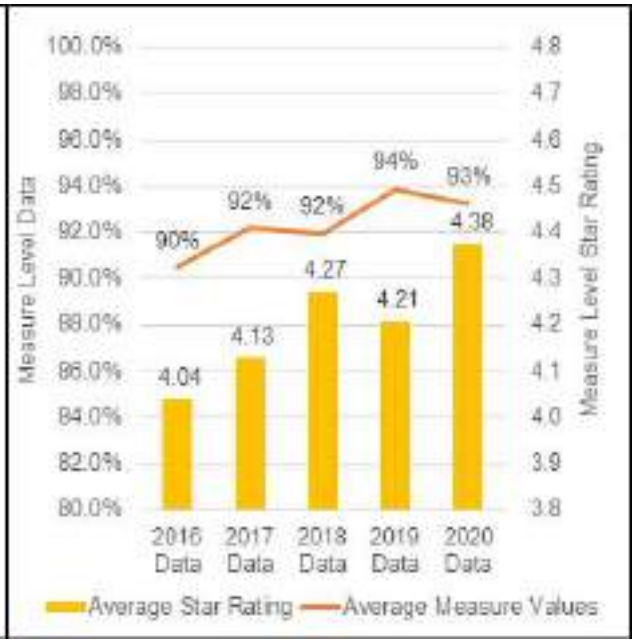


Figure 2
Access Measures[4]



Introduction and Background

The CMS Star Rating system was introduced in 2008 and began impacting MA spending in 2012. The system is designed to measure two major components of Medicare Advantage (MA) and Prescription Drug Plans (PDPs): 1) the quality of health and drug services received by beneficiaries, and 2) the experiences of enrolled beneficiaries.

The Star Ratings include measures applying to the following five broad categories:

1. **Outcomes**: Outcome measures reflect improvements in a beneficiary's health and are central to assessing quality of care.
2. **Intermediate Outcomes:** Intermediate outcome measures reflect actions taken which can assist in improving a beneficiary's health status.
3. **Process:** Process measures capture the health care services provided to beneficiaries which can assist in maintaining, monitoring, or improving their health status.
4. **Patient Experience and Complaints:** Patient Experience and Complaints measures reflect beneficiaries' perspectives of the care they received.

[3] Patient Experience/Complaints Measures are sourced from CAHPS surveys and CMS administrative data.

[4] Access Measures are sourced from data collected by CMS contractors.

5. **Access:** Access measures reflect processes and issues that could create barriers to receiving needed care.[5]

In addition to these categories, the Star Ratings include Part C and Part D improvement measures derived through comparisons of a contract's current and prior year measure scores across the majority of measures in the categories described above.

Table 1 shows the number of measures in each category under the 2020 Star Rating system, along with the weighting of each measure.

Table 1 –Stars Measures, 2020 Star Rating System

Star Rating Category	Number of Measures	Weight per Measure	Total Weight	% of Overall Star Rating
Outcomes	3	3.0	9.0	12%
Intermediate Outcomes	5	3.0	15.0	19%
Process	19	1.0	19.0	25%
Patient Experience and Complaints	10	1.5	15.0	19%
Access	6	1.5	9.0	12%
Improvement	2	5.0	10.0	13%

When combined, the Patient Experience/Complaints and Access measures represent 31% of the 2020 Overall Star Rating. CMS has proposed a significant weighting increase for these measures in the 2023 Star Rating system. Table 2 shows the proposed 2023 Star Rating weights for each measure category.

Table 2 –Stars Measures, 2023 Star Rating System (Proposed)[6]

Star Rating Category	Number of Measures	Weight per Measure	Total Weight	% of Overall Star Rating
Outcomes	3	3.0	9.0	8%
Intermediate Outcomes	5	3.0	15.0	14%
Process	19	1.0	19.0	17%
Patient Experience and Complaints	10	4.0	40.0	37%
Access	4	4.0	16.0	15%
Improvement	2	5.0	10.0	9%

If the weighting changes are implemented as outlined in the Proposed Rule, MAO contract performance in the Patient Experience/Complaints and Access measures will represent 52% of

[5] All results in this report exclude Access measures D02: Appeals Auto-Forward and D03: Appeals Upheld because CMS will remove these measures from the 2022 Star Ratings.
[6] With the exception of the two measures described above, this table contains only the proposed weight changes in 2023 and does not account for measures that will be added or removed between the 2020 and 2023 Star Ratings.

the 2023 Overall Star Rating. This is a significant increase, making the stability and predictability of these measures even more critical to ensure the stability of the Star Rating system.

America's Health Insurance Plans (AHIP) retained Wakely Consulting Group, LLC (Wakely), to analyze the variability in measure level cut points and performance over time for the Patient Experience/Complaints and Access Measures. MAOs use Star Ratings to gauge their over performance relative to other contracts, and variability in the cut points makes it more difficult for contracts to track changes in performance over time and make it difficult to compare performance relative to industry benchmarks. Also, to the extent beneficiaries use the Star Ratings program to aid in choosing between MA plans during the annual open enrollment period, variability in the cut points can make it difficult for beneficiaries to easily compare performance between plans via Star Ratings over time.

The remainder of this report analyzes the changes in measure level cut points and the impact that these changes have on MAO Star Ratings.

Summary of Key Findings

In order to observe the changes in contract quality performance and measure level Star Ratings, Wakely first gathered all available data from 2016 through 2020 Star Ratings and aggregated measure level performance, cut points and Star Ratings. For a full description of our methodology and assumptions, see Appendix A.

Volatility of Measure Level Data and Scores

Although there was not significant volatility in actual contract performance over time, the measure level Star Ratings connected to these performance results did vary. Figures 1 and 2 from the executive summary demonstrate the changes in average measure level performance and Star Ratings over time, shown separately for Patient Experience/Complaints and Access measures.

The measure level values in each year were averaged across all contracts and measures within each of the two categories. The majority of measures are "higher is better" measures, where a higher value indicates better performance; however, there are a few measures where "lower is better", i.e. a lower value indicates better performance. One example of these measures is C28: Complaints about the Health Plan. For these measures, we adjusted the values to:

$$\text{Lower is Better Adjusted Measure Value} = (1 - [\text{CMS Published Measure Value}])$$

After applying this change, we are able to combine the adjusted "Lower is Better" measure values with "Higher is Better" measure values in the same weighting category. We then calculate an average measure value across all contracts and all measures in the Patient Experience/

Complaints and Access measure categories.[7] We can also interpret an increase in the average measure value over time as an improvement, on average, in these categories.

Both Figures 1 and Figures 2 show there have not been large changes in average measure values between 2016 and 2020. The Patient Experience and Complaints Measures stay consistently between 84% and 86% in every year, and the Access measures show relatively steady improvement from 90% in 2016 to 93% in 2020.

Appendix B contains more detail on the historical performance of each Stars measure that contributes to the average Patient Experience/Complaints and Access measure values.

Figure 1 shows that average contract Star Ratings remained relatively unchanged for the Patient Experience and Complaints measures between 2016 and 2020. Although there have been slight changes in the unrounded average Star Rating each year, the rounded average Star Rating has remained at 3.5 every year.

Figure 2 shows that the average contract Star Rating for the Access measures has significantly more variability. The rounded average Star Rating varies from 4.0 in 2016, 2017, and 2019, to 4.5 in 2018 and 2020.

Contracts at each Measure Level Star Rating

Along with the variance in average measure level Star Ratings, the portion of contracts receiving each Star Rating changes materially from year to year. Figures 3 and 4 represent the number of contract measures assigned to each Star Rating across all measures within the Patient Experience/Complaints and Access measure groups.

[7] Measures that are on raw scale from 1 to 100 (rather than a percentage basis) were divided by 100 in order to maintain a consistent scale of 0 to 1 across all measures.

Figure 3 – Percent of Contract Star Ratings
Patient Experience and Complaints Measures[8]

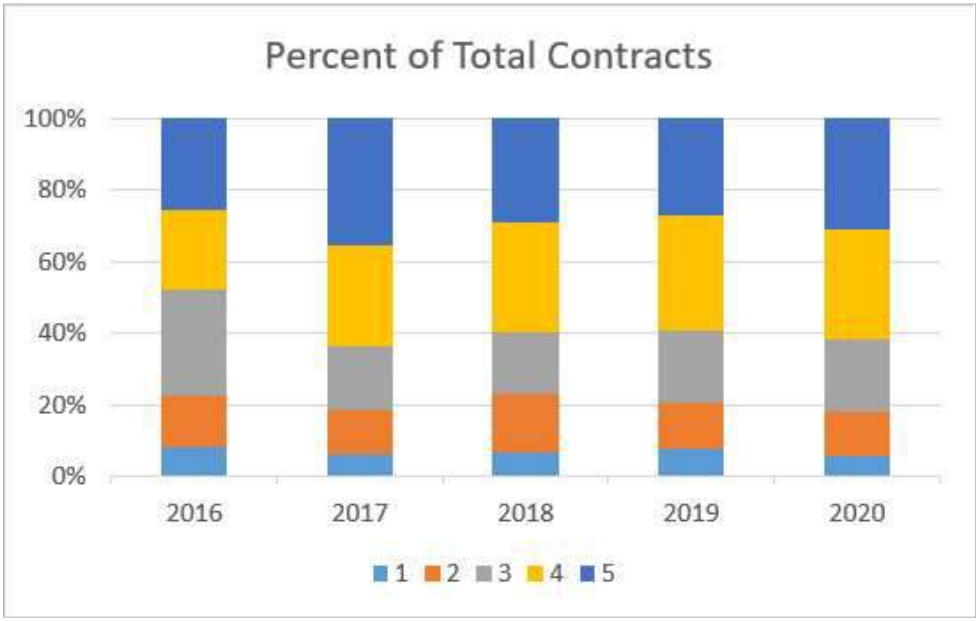
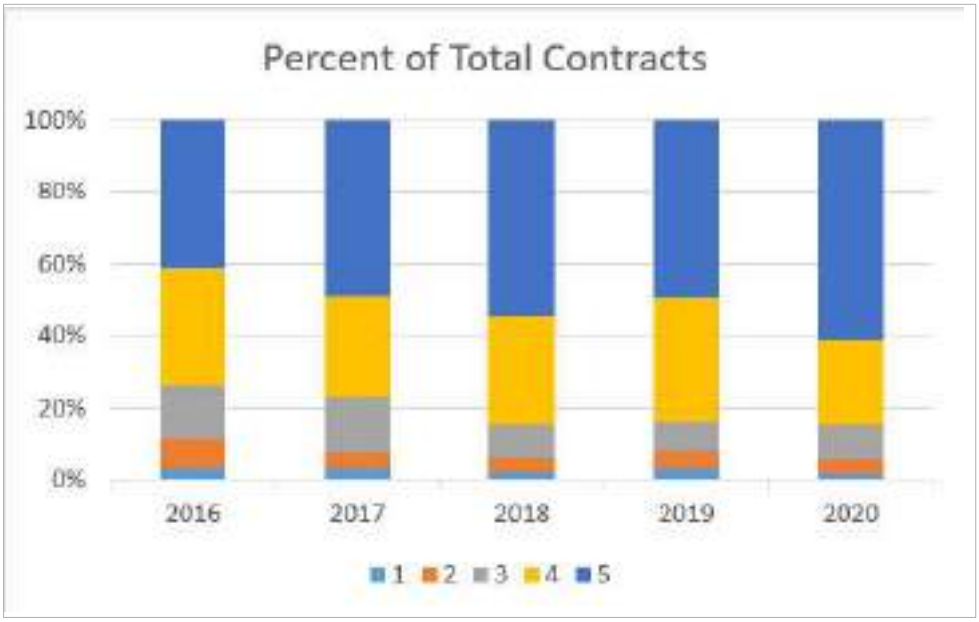


Figure 4 – Percent of Contract Star Ratings
Access Measures[9]



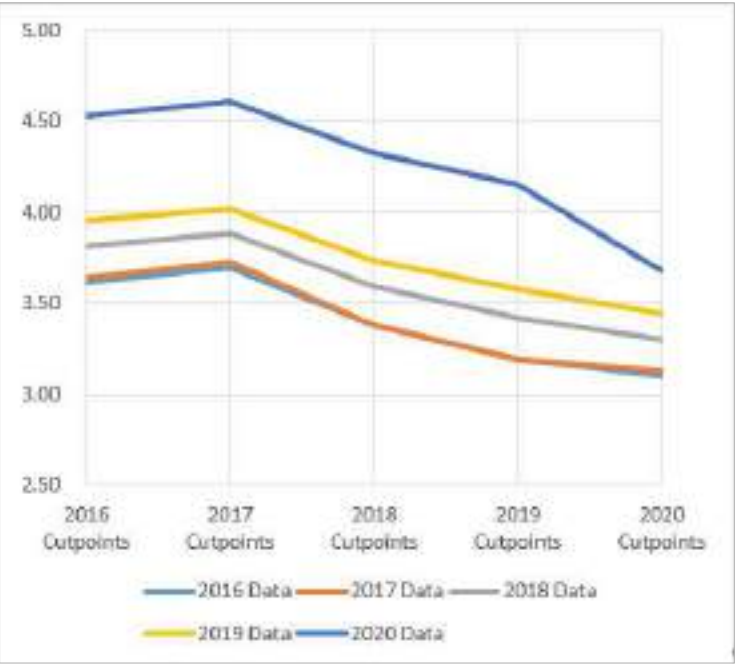
[8] Patient Experience/Complaints Measures are sourced from CAHPS surveys and CMS administrative data.
[9] Access Measures are sourced from data collected by CMS contractors.

Figures 3 and 4 illustrate the variability of Star Ratings from year to year. In particular, the portion of contracts that receive a 5.0 Star Rating varies widely each year. The portion of contracts receiving 5.0 Stars in Patient Experience and Complaints measures increased from 26% in 2016 to 36% in 2017, despite very little change in the weighted average value of these measures over the same time period from 84.4% to 84.2%.[10] Similarly, the Access measures experienced a small decrease in average value from 2017 to 2018,[11] but the portion of contracts with a 5.0 Star Rating increased from 49% to 55%. The volatility in contract Star Ratings is mainly driven by changes in cut points from year to year.

Impact of Changing Cut Points on 2020 Contract Level Performance

Finally, we used the measure level data from 2016 through 2020 and applied the changing cut points over the same time period. The darker blue lines in Figures 5 and 6 below represent the 2020 measure data applied to the cut points in each Star Rating year from 2016 through 2020. For example, average contract performance in the 2020 Patient Experience and Complaints measures, using the 2020 cut points, resulted in an average Star Rating of 3.68, but this same level of performance would have resulted in an average Star Rating of 4.53 using the 2016 cut points.

Figure 5 –Average Star Ratings
Patient Experience and Complaints Measures



[10] The change in average values described here is illustrated in Figure 1.
[11] The increase in average measure values is illustrated above in Figure 2.

Figure 6 –Average Star Ratings
Access Measures

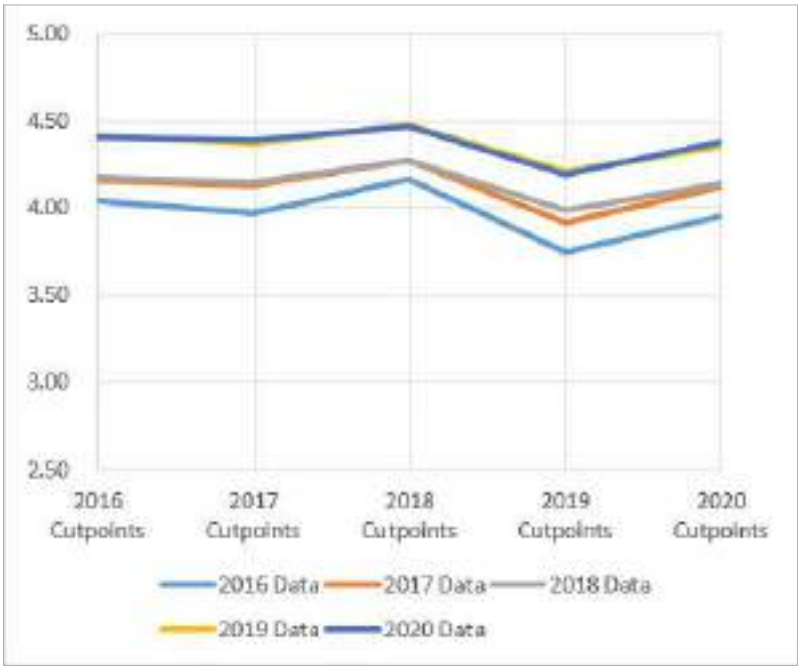


Figure 5 illustrates a significant decline in average Star Ratings for the Patient Experience and Complaints measures, even when keeping average contract performance in these measures constant. This large change over five years indicates the material impact of cut point changes on contract Star Ratings.

The Access measures trends in Figure 6 show a different pattern. Cut points for these measures have not steadily increased over time, and the average contract Star Ratings have increased or decreased in a seemingly random pattern each year, despite the fairly consistent improvement in measure level performance shown earlier in Figure 2. If an individual contract had consistent performance each year, its Star Rating would still increase or decrease purely due to cut point changes.

Conclusion and Key Takeaways

With the proposed increase in weight to the Patient Experience/Complaints and Access Measures in the 2023 Star Ratings, these measures will become more heavily weighted than any other measure groups. It is critical to understand the drivers of historical cut point volatility in these measures, and how this volatility impacts overall Star Ratings.

Historical cut point volatility in Patient Experience/Complaints and Access measures have contributed to volatility and inconsistent trends in contract Star Ratings.

There has been significant year-over-year volatility in average Star Ratings for Patient Experience/Complaints and Access measures, despite relatively consistent trends in plan performance over time. This volatility is primarily driven by the use of the clustering methodology, which has resulted in cut points that are not well correlated to changes in contract performance each year.

An increase in the weighting of Patient Experience/Complaints and Access measures could bring further instability to MAO Star Ratings.

As the intended purpose of the Star Ratings program is to compare contract performance on measures related to beneficiary health outcomes and experience, increasing the weights for these measures has the potential to erode the stability of the Star Ratings program by basing the majority of the Star Rating score on measures that have historically shown significant Star Rating volatility despite relatively stable performance in measure level data.

Disclosures and Limitations

Responsible Actuary Suzanna-Grace Sayre and Dani Cronick are the actuaries responsible for this communication. They are both Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the sole use of the America's Health Insurance Plans (AHIP) and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. We acknowledge that AHIP may provide the report to their participating health plans. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their actuarial experts in interpreting results. This information is confidential and proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this analysis are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. **Actual results may vary, potentially materially, from our estimates.** Wakely does not warrant or guarantee the projected values included in the analysis. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest We are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent to AHIP.

Data and Reliance We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any

independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Subsequent Events There are no known relevant events subsequent to the date of information received that would impact the results of this analysis. Differences or updates in the assumed contracts or risk and utilization of populations may cause deviation in results.

Deviations from ASOPS Wakely completed the analysis using sound actuarial practice. To the best of my knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations.

Appendix A - Methodology and Key Assumptions

In order to summarize the historical changes in measure level data as well as cut point and Star Rating changes, Wakely first gathered all publically available data for the 2016 through 2020 Star Ratings including measure level data, measure level cut points, measure level scores (Star Ratings), and overall Star Ratings. Because measures are added and removed over time, we focused the analysis on the most recent measures in the 2020 Star Ratings and compared performance using the same measures in prior years. Historical measures that were removed from the Star Rating system prior to the 2020 Star Rating year are not included in any of the summarized data presented in this report.

Summarizing Measure Level Data

For the majority of this report, measure level data and results is summarized at the weighting category level. For some measures, higher values do not achieve a higher Star Rating (e.g., for Plan All-Cause readmission, having a *lower* rate is better, but for Breast Cancer screenings, having a *higher* rate is better). In order to aggregate across all measures within a given category, we made several adjustments.

For measures where “higher is better” and the measure is on a 0-100% scale, no changes were made. For measures where “lower is better”, we calculated an adjusted measure value equivalent to one minus the measure level rating. After making this adjustment, higher values consistently indicate better quality performance in all measures. Finally, for measures where the data is reported a whole number instead of a percentage (e.g., in the 2020 Star Ratings, “Getting Needed Care” is a number from 1 to 100), the measure data was divided by 100 to adjust contract performance to a scale equivalent with the other measures.

After applying these adjustments, contract level data was then summarized for each year using a straight average approach. The weighted average approach was used to best align with how members and Medicare Advantage Organizations would be impacted by these results. Enrollment was pulled from December of each Star Rating year. For 2020, February Enrollment was used.

Applying Cut Points

After summarizing the publically available Star Rating data, we applied the measure level cut points for 2016 through 2020 to the measure level performance data from 2016 through 2020. The result was 25 different sets of measure level Star Ratings – 5 years of performance data times 5 years of cut points. The goal of this process was to determine:

1. If measure level performance were held constant over time (contracts did not have any improvement or deterioration in quality), how would their measure level Star Ratings change due to the changes in cut points alone?

2. If cut points were held fixed, how would measure level Star Ratings change over time due to changes in measure level performance alone?

For non-CAHPS measures, this involved selecting a period for the measure level data (e.g., in 2016 contract H1111 received 80% on the Breast Cancer Screening measure), and selecting a period for the measure level cut points (e.g., based on the 2018 cut points, an 84% would have yielded a 4 Star Rating for contract H1111 Breast Cancer Screenings Measure).

CMS applies a reliability factor to CAHPS measures that affects the assignment of measure level Star Ratings. It is not possible to calculate the reliability factor using the published Star Rating data, so we applied a simple calculation to derive the reliability factors. For each data year, the contract and measure level data for all CAHPS measures was compared to that year's measure level cut points and published measure level Star Ratings. When the resulting Star Rating did not match the published Star Rating, a reliability adjustment between -1 and +1 was derived to align the calculated Star Rating to the published Star Rating. This process was applied at the measure and contract level for all CAHPS measures, on all data years. The CAHPS reliability adjustment was then applied to the recalculated Star Ratings for every year (e.g., a 2016 CAHPS reliability adjustment was calculated based on 2016 data and 2016 cut points. This adjustment was then applied to the 2016 data with 2017 cut points, the 2016 data with 2018 cut points, and so on.). This approach assumes that the reliability factor remains constant even when measure level cut points change.

Exclusions and Caveats

There were several exclusions that were made for the purpose of this report. The focus of this report is MAO contract performance, therefore we have excluded Part D Plans (PDPs) from the analysis.

Appendix B – Measure Level Results

While the remainder of the report shows the change in average Patient Experience/Complaints and Access measures over time, this appendix illustrates each measure within these categories and the changes in measure level data and Star Ratings. The average amounts at the bottom of each table utilize the uniform metric described in Appendix A, where "Lower is Better" measures are inverted so that the average is one minus the published "Lower is Better" measure.

Figures B1 and B2 show the measure level data from 2016 through 2020 for Patient Experience/Complaints Measures and Access Measures.

Figure B1 – Patient Experience and Complaints Measure Data

Patient Experience and Complaints Measures	Data Source	Higher is Better?	2016 Data	2017 Data	2018 Data	2019 Data	2020 Data
C22: Getting Needed Care	CAHPS	Yes	83%	83%	83%	83%	83%
C23: Getting Appointments and Care Quickly	CAHPS	Yes	76%	76%	78%	78%	78%
C24: Customer Service	CAHPS	Yes	88%	88%	90%	90%	91%
C25: Rating of Health Care Quality	CAHPS	Yes	86%	86%	86%	86%	86%
C26: Rating of Health Plan	CAHPS	Yes	85%	84%	86%	86%	86%
C27: Care Coordination	CAHPS	Yes	85%	85%	86%	86%	86%
C28: Complaints about the Health Plan	CTM[1]	No	21%	24%	19%	17%	19%
C29: Members Choosing to Leave the Plan	MBDSS[2]	No	11%	11%	11%	10%	12%
D07: Rating of Drug Plan	CAHPS	Yes	84%	84%	84%	85%	85%
D08: Getting Needed Prescription Drugs	CAHPS	Yes	90%	91%	90%	90%	90%
Average of All Patient Experience and Complaints Measures			**84.4%**	**84.2%**	**85.2%**	**85.8%**	**85.4%**

[1] Complaints Tracking Module
[2] Medicare Beneficiary Database Suite of Systems

000574

Case 1:23-cv-03910-CJN Document 31 Filed 04/16/24 Page 159 of 717

Figure B2 – Access Measure Data

Measures Capturing Access	Data Source	Higher is Better?	2016 Data	2017 Data	2018 Data	2019 Data	2020 Data
C31: Plan Makes Timely Decisions about Appeals	IRE[3]	Yes	94%	94%	92%	96%	96%
C32: Reviewing Appeals Decisions	IRE	Yes	89%	90%	89%	91%	92%
C33: Call Center – Foreign Language Interpreter and TTY Availability	Call Center	Yes	89%	93%	93%	94%	93%
D01: Call Center – Foreign Language Interpreter and TTY Availability	Call Center	Yes	89%	92%	93%	94%	92%
Average of All Access Measures[4]			**90.5%**	**92.2%**	**92.0%**	**93.9%**	**93.2%**

[3] Independent Review Entity
[4] D02: Appeals Auto-Forward and D03: Appeals Upheld were both removed from this analysis since they are Access Measures that will be removed from the Stars Calculation for 2022 Star Ratings

000575

Case 1:23-cv-03910-CJN Document 31 Filed 04/16/24 Page 160 of 717

Figures B3 and B4 show the measure level Star Ratings from 2016 through 2020 for Patient Experience/Complaints and Access measures.

Figure B3 – Patient Experience and Complaints Measure Star Ratings

Patient Experience and Complaints Measures	Higher is Better?	2016 Star Ratings	2017 Star Ratings	2018 Star Ratings	2019 Star Ratings	2020 Star Ratings
C22: Getting Needed Care	Yes	3.5	3.3	3.4	3.3	3.3
C23: Getting Appointments and Care Quickly	Yes	3.4	3.3	3.3	3.4	3.4
C24: Customer Service	Yes	3.5	3.3	3.4	3.4	3.5
C25: Rating of Health Care Quality	Yes	3.4	3.4	3.4	3.3	3.3
C26: Rating of Health Plan	Yes	3.3	3.2	3.2	3.3	3.2
C27: Care Coordination	Yes	3.4	3.4	3.3	3.4	3.4
C28: Complaints about the Health Plan	No	3.9	4.6	4.3	4.1	4.9
C29: Members Choosing to Leave the Plan	No	4.2	4.3	4.0	3.9	3.9
D07: Rating of Drug Plan	Yes	3.3	3.3	3.2	3.2	3.0
D08: Getting Needed Prescription Drugs	Yes	3.4	3.6	3.4	3.5	3.5
Average of All Patient Experience and Complaints Measures		**3.8**	**3.53**	**3.58**	**3.48**	**3.50**

Figure B4 – Access Measure Star Ratings

Patient Experience and Complaints Measures	Higher is Better?	2016 Star Ratings	2017 Star Ratings	2018 Star Ratings	2019 Star Ratings	2020 Star Ratings
C31: Plan Makes Timely Decisions about Appeals	Yes	4.1	4.0	4.0	4.2	4.5
C32: Reviewing Appeals Decisions	Yes	3.6	4.0	4.0	4.0	4.1
C33: Call Center – Foreign Language Interpreter and TTY Availability	Yes	4.3	4.2	4.5	4.3	4.3
D01: Call Center – Foreign Language Interpreter and TTY Availability	No	4.2	4.3	4.5	4.3	4.6
Average of All Access Measures		**4.04**	**4.13**	**4.27**	**4.21**	**4.38**

000576

Case 1:23-cv-03910-CJN Document 31 Filed 04/16/24 Page 161 of 717

TAB 7

PUBLIC SUBMISSION

As of: January 25, 2024
Received: April 06, 2020
Status: Posted
Posted: April 10, 2020
Tracking No. 1k4-9fz7-e6ib
Comments Due: April 06, 2020
Submission Type: Web

Docket: CMS-2020-0010
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2021 (CMS-4190-P)

Comment On: CMS-2020-0010-0002
Medicare and Medicaid Programs: Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Document: CMS-2020-0010-0481
Comment on CMS-2020-0010-0002

Submitter Information

Name: Amanda Hurley
Organization: Anthem

General Comment

Dear Administrator Verma:

Anthem, Inc. ("Anthem") appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') "Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly," proposed rule.

I have attached Anthem's comment letter. As a committed participant in the Medicare Advantage and Part D programs, we look forward to continuing to work with CMS on these important issues. Should you have any questions or wish to discuss our comments further, please contact us.

Attachments

2020.04.06_Anthem Comments on MA-PD Regulation for 2021 and 2022

Anthony Mader
Vice President, Public Policy
Anthem, Inc.
1121 L Street
Sacramento, CA 95814
(916) 403-0522

Anthem.

Submitted via Federal e-Rulemaking Portal: https://www.regulations.gov

April 6, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4190-P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: CMS-4190-P

Dear Administrator Verma:

Anthem, Inc. ("Anthem") appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') "Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly," proposed rule, published on February 5, 2020.

Anthem shares CMS' commitment to preserve and strengthen the Medicare Advantage (MA) and Part D programs. We deliver high quality services to improve beneficiaries' health and well-being by working with CMS to offer affordable and patient-centered coverage options. We commend CMS for proposing a number of streamlining and clarifying guidance that support these goals. We are also concerned with certain CMS proposals that would negatively impact beneficiaries and the operation of the MA and Part D programs. Below are Anthem's recommendations on key issues at a high level followed by our detailed comments and recommendations.

Executive Summary

1. Provide Clear and Timely Guidance during Public Health Emergency

The health and well-being of our beneficiaries is of the utmost importance. We are closely monitoring the 2019 Novel Coronavirus (COVID-19) pandemic developments and instituting policies to ensure our beneficiaries continue to have access to high quality, affordable healthcare during this rapidly evolving public health emergency. We have taken steps to eliminate the burden of additional costs for our beneficiaries by providing coverage of the coronavirus screening test and treatment at no out-of-pocket-cost, and ensuring prior authorization is not required for diagnostic services related to COVID-19 testing. We have also relaxed early prescription refill limits for beneficiaries, and we will waive any cost-sharing for telehealth visits, including visits for mental health providers, for 90-days to help prevent the virus from spreading further.

We recognize the Administration is actively working to respond to COVID-19 by recently releasing an interim final rule, and issuing guidance to inform Medicare Advantage Organizations (MAOs) and Part D Sponsors of obligations and flexibilities. As plans prepare coverage offerings for 2021, we encourage CMS to consider the impact of COVID-19 on the strength of the MA program.

Clear and timely guidance is needed on how CMS will account for the impact of COVID-19 on plan bids, benchmarks, potential mid-year rate adjustments, risk adjustment, and Star Ratings to ensure the availability of adequate resources to care for all beneficiaries, including those vulnerable to this infectious disease. As plans develop benefit packages for 2021 we encourage CMS to take the following actions to ensure the stability of the MA and Part D programs:

- Bid timeline: Provide clear guidance on COVID-19 and the impacts of the virus on rates, bids, and benchmarks. Given the already tight timeframe, we do not support extending the bid timeline, and instead recommend CMS relax documentation requirements for bid development such as waiving the requirement to file End Stage Renal Disease (ESRD) bids, providing plans with assumptions around Fee-for-Service (FFS) Medicare cost trends, and waiving desk review if a plan freezes 2021 benefits at 2020 levels.

- Risk adjustment: We recommend CMS allow telehealth visits as valid encounters for the documentation of diagnosis codes used for the calculation of MA risk scores during the public health emergency. Such guidance is consistent with CMS' decision that face-to-face visits can be furnished via telehealth in FFS for payment purposes due to COVID-19 in the interim final rule, and the recommendation that older Americans remain home and avoid seeking any non-urgent healthcare. We also ask CMS to leverage previous data that supports the diagnosis of a chronic condition that cannot be cured to avoid burdening providers with requests for medical records. In addition, we would recommend the 2020 final payment period be held open until January 2022, instead of the typical timeframe of January 2021 to reduce the burden on providers working to stop the spread of this virus.

- Program flexibilities: We request additional guidance and flexibilities on drug quantity limits that may be effective in treating COVID-19 to avoid shortages. CMS should also issue guidance giving plans the option to exceed supplemental benefit limits to provide additional food to beneficiaries, expand access to currently approved transportation assistance if public transportation has been suspended, and provide additional over-the-counter benefits for health related items beneficiaries may need to shelter in place such as blood pressure cuffs. In addition, we encourage CMS to expand the use of home health beyond the FFS benefit to help prevent beneficiaries from leaving their homes and potentially spreading the virus further.

- Enforcement Standards: We appreciate CMS' guidance delaying auditing and monitoring activities. We encourage the agency to continue clarifying how such activities will be impacted moving forward to enable plans to focus resources on the COVID-19 response.

2. Modify Star Ratings in 2021 and 2022 Beyond Extreme and Uncontrollable Circumstances Policies to Accurately Account for Impact of COVID-19

Anthem is committed to providing beneficiaries with access to high quality care and support services during the COVID-19 pandemic. As CMS and states have quickly adapted to provide care during the public health emergency, we encourage the agency to make necessary changes to the 2021 and 2022

Star Ratings to enable plans to fully shift their focus and attention to improving beneficiary care under these unique circumstances, and redeploy trusted resources to help members remain safely in their homes to help avoid the further spread of the virus.

While we appreciate CMS' proposals in the interim final rule to modify the calculation of the 2021 and 2022 Part C and D Star Ratings to address the disruption to data collection and measure scores, we are concerned the agencies proposal does not fully account for the impact of the COVID-19 public health emergency on Star Ratings.

In the short-term, CMS and MAOs should ensure Star Ratings activities do not require efforts counterproductive to the work of providers to combat the virus, or to the health and safety of beneficiaries. The Star Ratings should not require plans to submit requests to providers for medical records, or encourage beneficiaries' to seek non-emergent care during the public health emergency.

In the long-term, we encourage CMS to develop an industry-wide standard that appropriately measures quality during this pandemic. This approach – which could be operationalized using the agency's demonstration authority – should carry forward the Quality Bonus Payments (QBPs) for 4 and 5-Star plans, and provide plans with 3.5 or 3 Star Ratings the opportunity to earn a QBP for contract years 2022 and 2023 (2021 and 2022 Star Ratings) of at least 3.5 percent.

If CMS does not update the Star Ratings program to fully account for COVID-19, then, at a minimum, the agency should expand the extreme and uncontrollable circumstances policy to account for the pandemic and use data from the most recent unaffected year.

Currently, the potential for relief through the "extreme and uncontrollable circumstances" policy is limited to areas where Federal Emergency Management Agency (FEMA) major disasters have been declared and individual disaster assistance has been approved. CMS should expand eligibility for the policy to recognize federal, state, and local public health, emergency and disaster declarations. Expanding the current policy will ensure that beneficiaries are not unfairly penalized by fewer plan benefit options when quality thresholds are impacted by extreme and uncontrollable circumstances.

Specifically, we ask CMS to expand eligibility for the policy in the event of a state or local public health emergency, if the Secretary of Health and Human Services (HHS) declares a public health emergency, or in the event of a FEMA emergency or Fire Management Assistance Grant (FMAG) declaration for which public or individual assistance is available. Expanding CMS' recognition of these declarations and providing relief across multiple years will ensure quality measures are fairly applied across the country.

3. Proceed Cautiously on Curtailing Dual Eligible Special Needs Plan (D-SNP) Look-Alikes to Minimize Disruption to Beneficiaries

Anthem is committed to the enrollment of full-benefit dual eligible beneficiaries into D-SNPs that meet new integration requirements, and we appreciate the flexibility CMS has provided to implement these requirements in the most appropriate way for each state. However, we are concerned that if CMS moves forward with its proposal to curtail D-SNP look-alikes, the agency could disrupt beneficiary services and benefits.

We encourage CMS to implement any proposal regarding D-SNP look-alikes with sensitivity towards both continuity of care and the nuances of state requirements and market dynamics that conflict with

CMS' proposal. Specifically, we support CMS' proposal to allow D-SNP look-alike plans in states where D-SNPs or other integrated plans currently do not operate—in these states, look-alike plans provide valuable extra benefits to dual eligible beneficiaries that would not be available in a traditional MA benefit design.

We also request CMS extend this exception to counties or local markets where D-SNPs do not exist, since we are aware of instances where the state may allow for new D-SNPs, but the creation of a D-SNP is restricted at the market or county level, such as in California.

We believe that CMS' proposed definition of look-alikes as MA plans with at least 80 percent dual eligible membership is an appropriate threshold, assuming it applies only to full-benefit dual eligible beneficiaries. Given the potential disruption in care to a number of beneficiaries currently in high-performing four or five star plans even under this definition, we do not think the threshold should be any lower (since a lower threshold would negatively impact even more beneficiaries currently in high-performing plans), nor should it include partial duals (for which look-alike plans can provide benefit choice that better meets beneficiaries' needs).

If this proposal is finalized, we also encourage CMS to delay implementation by at least one year, until 2023 or later, to allow MAOs the opportunity to file bids and align with CMS' goals to avoid disruption in beneficiaries' care as they transition into other plans. Given the current COVID-19 crisis, states will also likely need additional time to approve new D-SNPs and help coordinate the transition process. This will ensure that beneficiaries are not negatively impacted, choice remains, and confusion is minimalized.

4. Enhance Care for ESRD Beneficiaries in MA by Improving Benchmark Accuracy and Expanding Access to Value-Based Care

In 2021, as directed by the 21st Century Cures Act, all ESRD patients will be eligible to enroll in MA. This new policy will lower Out-of-Pocket (OOP) costs for ESRD beneficiaries and expand access to new supplemental benefits to address drivers of health, including care coordination services not available in FFS.

In addition, the Administration's Advancing Kidney Health in America initiative creates new opportunities to improve the lives of Americans suffering from kidney disease. We support the goals of this initiative, as well as the changes of the 21st Century Cures Act as we have experience managing the specialized care associated with ESRD patients.

Given this significant change in policy, and our collective desire for successful implementation, we encourage CMS to address the inadequacy of the MA benchmarks and expand access to value-based care options for ESRD patients. We are concerned all MA beneficiaries could be negatively impacted through increased premiums, decreased benefits, and fewer plan options due to the higher costs associated with caring for beneficiaries with ESRD.

We appreciate that CMS acknowledges current ESRD reimbursement is not sufficient to prevent premium increases to accommodate the higher costs of ESRD beneficiaries in MA, particularly given that MA plans have a mandatory Maximum Out-of-Pocket (MOOP) limit that most, if not all, beneficiaries

with ESRD will surpass. In fact, applying the MOOP to ESRD beneficiary spending increases MA costs by an estimated 8 to 9 percent on average compared to FFS spending.[1]

To account for this inadequacy, CMS proposes to enable MA plans to increase MOOP limits. However, this change does not go far enough to mitigate the costs of ESRD beneficiaries, and a higher MOOP would increase OOP costs for all MA beneficiaries.

MA plans have a mandatory MOOP, while ESRD payments are based on FFS that does not have a MOOP. Plans will have to cover the increased costs of caring for ESRD beneficiaries by raising premiums by as much as $18 Per Member Per Month (PMPM), cutting benefits, or limiting plan options for all beneficiaries if CMS does not account for the value of the MOOP in setting MA ESRD benchmarks.[2] These long-standing policy concerns were raised to CMS by two of the sponsors of the 21st Century Cures Act that expanded ESRD patients' access to MA, Representatives Jason Smith (R-MO) and Gus Bilirakis (R-FL).[3]

Anthem is also concerned CMS' estimate of kidney acquisition costs is inflated. We encourage CMS to re-evaluate the estimate of kidney acquisition costs and make the underlying cost and discharge data more transparent, while considering MA plans' data and actual experience before removing $4 PMPM from the benchmark.

In order to ensure the continuation of low OOP costs, expanded supplemental benefits, including special supplemental benefits for the chronically ill, and care coordination services, CMS should directly address the payment inadequacies for ESRD beneficiaries in MA by updating the benchmarks.

In addition, to expand beneficiaries' access to value-based models of care, we encourage the Administration to allow MA plans to participate in the Center for Medicare & Medicaid Innovation (CMMI) kidney models, expand the list of Chronic Condition Special Needs Plans (C-SNPs) conditions to include patients with Chronic Kidney Disease (CKD), and provide flexibilities in network standards for dialysis services.

5. Update Past Performance Methodology to Account for Persistent Performance Issues

While Anthem appreciates CMS' efforts to clarify and simplify the past performance methodology, we are concerned the proposal would be overly restrictive in its application. We do not believe the proposed methodology sufficiently takes into account the nature and context of performance issues over a long enough period of time, and would inadvertently limit new high-quality plan offerings for beneficiaries.

Given the negative impact COVID-19 will have on Star Ratings, we recommend that CMS does not consider low Star Ratings as a determining factor to deny new contract and service area expansions. At a

[1] Health Management Associates. "End-Stage Renal Disease and Medicare Advantage." February 12, 2019. https://www.healthmanagement.com/wp-content/uploads/Health-Management-Associates-ESRD-and-Medicare-Advantage-White-Paper.pdf.

[2] Wakely. "2021 Medicare Advantage Advance Notice." March 4, 2020. https://www.ahip.org/wp-content/uploads/CY2021-Advance-Notice-Summary-and-Analysis-03-04-2020.pdf.

[3] Representatives Jason Smith (R-MO) and Gus Bilirakis (R-FL). January 13, 2020. https://share.antheminc.com/teams/PublicPolicy/Resource/Bilirakis-Smith_CMS_Ltr_ESRD_Choice_Act_Implementation(2020-1-13).pdf#search=Bilirakis.

minimum, we encourage the agency to consider two to three years of Star Ratings performance to allow for improvement efforts to be measured and reported.

Additionally, given the narrow timeframe CMS proposes for review, we encourage the agency to provide plans with a remediation opportunity and an appeals process should the plan quickly address identified issues.

Lastly, we recommend CMS exclude plans from the past performance review which have been, or will be non-renewed prior to the following contract year. Such a policy would enable plans to refocus efforts on ensuring existing Medicare contract performance remains at an acceptable level, and expanding high-quality plan choices to beneficiaries' in new service areas.

While we have concerns with the proposed methodology updates, we appreciate CMS' acknowledgement that given the new requirements of the Bipartisan Budget Act of 2018 (BBA) for D-SNPs, more intermediate sanctions should not be tied to overall contract performance.

6. Ensure Foundation of Star Ratings Continues to be Based on Objective Clinical Measures

Anthem opposes increasing the weight of patient experience and complaint measures to 4, well above the weight of clinical outcome measures. Any change regarding the weight of these measures should be preceded by a critical evaluation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and the Health Outcomes Survey (HOS) given concerns about decreasing response rates, and the accuracy and reliability of survey results.

While we appreciate the importance of ensuring patients have a positive experience and appropriate access to care, we encourage a slower and more thoughtful approach to changes to ensure the Star Ratings, which beneficiaries use to make plan choices, take a balanced approach to patient experience, and objective clinical outcomes.

7. Retain a Weight of 1 for the Statin Use in Persons with Diabetes (SUPD) Improvement Measure

While Anthem supports the goal of ensuring quality care for patients with diabetes, we believe the SUPD measure is more appropriately categorized as a process improvement measure. In addition, we encourage CMS to allow for clinically appropriate exclusions to improve the accuracy of the measure.

We are concerned that CMS is proposing to classify the SUPD measure as an intermediate outcome measure with a weight of 3 in the 2021 and 2022 Star Ratings Improvement Measures. Implementing the SUPD measure with a weight of 1 for the 2020 Star Ratings, reclassifying the measure and increasing the weight to 3 for 2021 and 2022, and then again reclassifying the measure and reducing the weight to 1 for 2023 is inconsistent and does not align with the guidance of expert measure developers.

We encourage CMS to make a technical correction to existing regulations to keep the SUPD measure at a weight of 1. This would align with both the Pharmacy Quality Alliance's (PQA's) classification of the SUPD measure as a process measure as well as the National Quality Forum's (NQF's) definition of a process measure.[4] Furthermore, in the 2020 Final Notice, CMS expressed agreement with stakeholder

[4] PQA. "Statin Use in Persons with Diabetes." Accessed February 25, 2020. https://www.pqaalliance.org/measures-overview#supd.

comments that the SUPD measure should retain a weight of 1 as a process measure, rather than a weight of 3 as an outcome measure.

In addition to our concerns around the measure classification and increased weighting, the COVID-19 public health emergency could impact beneficiaries' adherence, negatively impacting the accuracy of the measure. Furthermore, the measure does not allow for clinically appropriate exclusions to acknowledge certain demographic groups are more likely to be predisposed to statin intolerance.[5]

8. Account for Social Drivers of Health (SDOH) and COVID-19 in the Medical Loss Ratio (MLR)

This proposed rule change would establish the leadership of this Administration as the first to incorporate SDOH into the MLR framework. Anthem supports enabling social investments to be included in the MLR numerator, and appreciates CMS' proposed change to the definition of incurred claims to allow for an accurate accounting of SSBCI benefits.

Given the public health emergency, we also encourage CMS to allow investments in combating COVID-19 to be considered as incurred costs, thereby allowing such investments to be applied to the numerator of the MLR.

Including investments associated with SDOH, such as SSBCI benefits, and combating COVID-19 in the MLR numerator would further strengthen the MA program and support whole person health.

9. Implement Network Adequacy Flexibilities to Improve Beneficiaries' Access to Care

Anthem supports CMS' proposed flexibilities to the MA network adequacy requirements. CMS' approach reflects the challenges associated with establishing a network in some geographies and would improve beneficiaries' access to plan options in rural areas, as well as access to telehealth innovations to close care gaps.

Given the expected increase in ESRD beneficiary enrollment in MA, we support CMS' proposal to remove outpatient dialysis from the list of facility types for which MA plans must meet time and distance standards, and instead allow plans to attest to providing medically necessary dialysis services in contract applications. These flexibilities will encourage competition and drive patient-centered innovation in dialysis treatment.

Given the challenges associated with the COVID-19 outbreak, we also appreciate that CMS has proposed flexibilities when plans contract with telehealth providers. We request further clarification on how health plans can expand coverage of telehealth services beyond those approved by CMS.

10. Require Submission of Pharmacy Claims and Allow Attestations to Improve Patient Safety and the Accuracy of Star Ratings

Anthem is concerned patient safety and Star Ratings accuracy are compromised when a beneficiary obtains a medication without utilizing their prescription drug benefit, and their pharmacist does not file a claim.

[5] Zahid Ahmad, MD. "Statin Intolerance." May 2014. https://www.ajconline.org/article/S0002-9149(14)00725-5/pdf.

Safety issues arise when a plan does not know a beneficiary has obtained a prescription medication. In these situations, plans are unable to appropriately monitor safety issues such as dangerous drug interactions, opioid use, or duplicate therapies. It is critical that plans are able to conduct concurrent drug utilization reviews to ensure patient safety.

We ask CMS to require a pharmacy claim submission process for cash payments, and permit plans to submit attestations to show the beneficiary received their medication for purposes of calculating Star Ratings measures. This will address situations in which beneficiaries have extended gaps in their fill histories, while other supplemental data shows they received their medication.

Moving forward, we encourage CMS to develop a repository with pharmacy records so plans can better monitor prescribing and dispending patterns. These policy changes will improve patient safety and the accuracy of medication adherence measures in the Star Ratings program.

11. Account for Volatility in Specialty Drug Prices in the Medicare Plan Finder (MPF) Star Ratings Measure to Improve Accuracy of Drug Prices for Beneficiaries

Since drug prices are volatile due to manufacturers' ability to change prices at any time without warning or constraint, Anthem is concerned the MPF can exhibit inaccurate information to the consumer as compared to the cost at the Point-of-Sale (POS).

We are also concerned that it can take two to four weeks to update pricing changes submitted by any Pharmacy Benefit Manager to the MPF leading to higher dollar discrepancies for beneficiaries at the pharmacy counter.

Therefore, we request that CMS allow for the correction of specialty drug prices during the Star Ratings plan preview window to improve the accuracy of high-priced drug costs for beneficiaries. We would also like to work with CMS to increase the efficiency of the process for updating drug prices on the MPF.

Given that challenges ensuring the accuracy of prescription drug costs on the MPF are expected to persist, we request CMS consider an exceptions process to hold plan Star Ratings harmless with proof a drug price has changed significantly over a two-week period.

Detailed Comments on Provisions in the Proposed Regulation

A. Implementation of Certain Provisions of the Bipartisan Budget Act of 2018

Special Supplemental Benefits for the Chronically Ill (SSBCI) (§ 422.102)

Recommendation Summary: Anthem strongly supports CMS' proposal to give plan sponsors more flexibility in the delivery of supplemental benefits for chronically ill beneficiaries. We appreciate additional flexibility in the definition of eligible populations because MA plans are in the best position to coordinate care for beneficiaries with chronic conditions for whom SSBCI would have the largest benefit.

We encourage CMS to implement this flexibility within existing administrative reporting requirements so innovations can be implemented without new or conflicting administrative burdens. We also encourage CMS to test ways to provide more flexibility in targeting supplemental benefits to address social risk factors like homelessness. Furthermore, we would like to work with CMS to identify ways beneficiaries can be better educated about SSBCI benefits within the MPF.

Recommendation Detail: Anthem has embraced the new flexibility provided by CMS through SSBCI benefits, as well as the expanded definition of primarily health related supplemental benefits. We are also testing prescribed nutrition programs, respite care, pain management, and an outreach support program to address loneliness and isolation. Specifically, in 2020, beneficiaries in our MA plans may have access to the following:

1) Pest Control: Quarterly preventive treatments to regulate or eliminate the intrusion of household pests that may impact a chronic condition;
2) Healthy Nutrition: Based on qualifying clinical criteria, access to eight sessions per year with a dietitian who can provide nutritional education support as well as monthly delivery of pantry staples (nonperishable items) to help make dietary changes;
3) Health and Fitness Tracker: The beneficiary is provided a fitness tracker device as well as membership in programs to promote improved physical and mind fitness;
4) Service Dog Support: Up to $500 annual allowance to help pay for items used to care for a member's service dog, such as leashes and vests;
5) Healthy Food Deliveries: Up to 16 delivered meals four times each calendar year (64 total) to support beneficiaries who are either discharged from an overnight stay at a hospital, have a Body Mass Index (BMI) more than 25 or less than 18, or have an A1C level more than 9.0;
6) Transportation: Up to 60 trips per year to health-related appointments or to obtain a service covered by the health plan;
7) Personal Home Helper: Up to 124 hours of an in-home personal care aide for assistance with activities of daily living such as dressing, grooming, & bathing;
8) Assistive Devices: Up to a $500 allowance for safety devices such as Americans with Disabilities Act (ADA) compliant toilet seats, shower stools, hand-held shower heads, and reaching devices;
9) Day Center Visits: One visit per week for adult day center services, in order to help older adults who need supervision and assistance; and
10) Alternative Medicine: Up to 24 acupuncture and/or therapeutic massage visits each calendar year.

We support CMS' proposal to allow for the identification of beneficiaries beyond the current list of chronic conditions as long as they meet the standards of chronically ill as defined by the statute. To this

end, while CMS works to roll out this new flexibility, we encourage the agency to seek feedback from plans on how to report eligibility criteria consistently so that innovations can be implemented without new or conflicting administrative burdens.

We recommend CMS provide plans with more flexibility in targeting supplemental benefits to address social risk factors. Today supplemental benefits can address SDOH as long as they maintain or improve health function, and don't solely address social factors. SDOH alone cannot be used to determine SSBCI eligibility. We encourage CMS to work with CMMI to test benefits targeted at SDOH challenges, such as homelessness.

Specifically, we encourage CMS to pilot a Special Needs Plan (SNP) addressing homelessness to test the effectiveness of this model of care for people experiencing homelessness or housing instability, with the goal of achieving better clinical outcomes, a lower rate of homelessness, and lower overall system costs. This strategy could be particularly effective for patients whose homelessness is associated with mental health conditions, substance use disorders, and/or other debilitating medical conditions. Benefit flexibility would be a critical component of the homeless SNP pilot program to establish appropriate solutions to reduce the number of homeless individuals in Medicare.[6]

Furthermore, while Anthem has embraced the inclusion of SSBCI benefits into our plan designs for 2020, we believe CMS could do more to help educate beneficiaries about their plan and benefit options through tools such as the MPF. Currently, the MPF only displays a subset of the supplemental benefits in the overview page and requires the beneficiary to click on plan details for a full list of the supplemental benefits. We are concerned this extra step could prevent a beneficiary from learning about all of their supplemental benefit options and fully evaluating plan choices. CMS currently publishes OOPC estimates on the MPF, but CMS has shared that the costs for optional supplemental benefits are not included in the calculation of OOPCs. Therefore, the current OOPC model does not accurately capture the actuarial impact for the beneficiary.

SSBCI benefits are included in plan designs alongside other traditional supplemental benefits—and plans must make choices of what mix of the two to include. However, we are concerned that in the MPF, plans are ordered, and therefore penalized based on cost. To ensure beneficiaries can consider the full spectrum of health plan offerings, we recommend CMS increase the visibility of new supplemental benefit offerings and incorporate the value of supplemental benefits into the OOPC model calculations.

Improvements to Care Management Requirements for Special Needs Plans (SNPs) (§422.101)

Recommendation Summary: Anthem supports CMS' desire to ensure that beneficiaries in C-SNPs, and the providers that care for them, are engaged in the care plan. However, we do not believe the proposed implementation of the BBA's C-SNP requirements provide either enough flexibility or specificity to meet beneficiaries' needs while still reaching Model of Care (MOC) benchmarks.

Anthem also does not support extending these C-SNP requirements to D-SNPs and Institutional-SNPs (I-SNPs) since such a policy would result in duplicative and inconsistent requirements, given the many existing related requirements already in place.

[6] JAMA. "Homeless Special Needs Plans for People Experiencing Homelessness." February 13, 2020. https://jamanetwork.com/journals/jama/fullarticle/2761555.

Recommendation Detail: CMS proposes to update its regulations to extend the BBA's C-SNP requirements to other SNP care management and MOC submissions. We have the following comments on the implementation of the elements of the new requirements:

- Interdisciplinary Team (IDT): The BBA requires that the interdisciplinary team include a team of providers with demonstrated expertise. We recommend that CMS implement requirements related to the documentation of the care team—rather than implement prescriptive requirements for the composition of a care team. This approach provides beneficiaries with choice regarding caregivers and thus the greatest chance for success in meeting CMS' MOC goals.

  Anthem undergoes a rigorous credentialing process to ensure that its network providers have the expertise and training to care for MA beneficiaries that enroll in our plans. Additionally, Anthem fully complies with network adequacy requirements to ensure our networks have all necessary providers overall and within proximity to beneficiaries. Because of the rigor of these current requirements, we believe that MA plans' networks already have providers to care for any set or subset of beneficiaries that may enroll.

  For I-SNPs and D-SNPs, this requirement is not appropriate. For I-SNPs, the institutional settings in which many beneficiaries reside already have staffing and physician supervision requirements that CMS believes are necessary for quality long-term care. Adding additional IDT requirements will increase the burden on long-term care facilities and may require some patients to be managed to different standards than others, which should not be necessary since plans already promote the identification of providers from disciplines that are most relevant to the beneficiary's needs.

  For D-SNPs, given the diverse needs of this population (some of whom are not chronically ill), we believe the credentialing and network adequacy standards that are in place ensure appropriate access to high-quality providers. We note that many states already include additional provider network requirements for specific sub-populations that could vary from and conflict with these C-SNP requirements.

- Face-to-Face Annual Encounters: The BBA requires that C-SNPs provide face-to-face encounters with beneficiaries not less frequently than on an annual basis. We encourage CMS to allow for any face-to-face encounter with a provider to meet this requirement. For example, if a beneficiary chooses to engage through their primary care physician, then that interaction should be counted. For I-SNPs, given the existing requirements related to patients in long-term care, such a requirement would be duplicative. For D-SNPs, certain sub-populations of D-SNP beneficiaries would benefit from annual face-to-face encounters; however, we believe the better place to standardize this process is through specific types of SNPs, such as Highly Integrated Dual Eligible SNPs (HIDE-SNPs) and Fully Integrated Dual Eligible SNPs(FIDE-SNPs), rather than as part of broad MOC requirements. While the vast majority of beneficiaries in SNPs are receiving ongoing, regular care from a multidisciplinary team, there are a subset who chose not to obtain routine medical care. Even though Anthem strongly encourages annual wellness visits at a minimum for these individuals, it is ultimately the choice of the beneficiary to engage in the health care system.

Additionally, we would encourage CMS align all evaluation and documentation requirements to the calendar year in order to align these processes with benefits such as the annual wellness visit.

- Health Risk Assessments (HRAs) and the SNP Beneficiary's Individualized Care Plan: The BBA requires that as part of the mandatory MOC, the results of the initial assessment and annual reassessment required for each beneficiary be addressed in the individual's individualized care plan. We recommend that CMS allow for as much flexibility as possible and clarify that the care plan is a collaborative document between the beneficiary and their care team. A care plan is designed to prioritize the beneficiary's needs and facilitate interventions where coordination and support may be lacking. As such, not every issue identified in an HRA becomes part of the care plan (for example, a beneficiary may report in an HRA something that is not relevant to the care plan or is not a covered benefit), and conversely a care plan may address additional issues not part of an HRA. If this requirement is implemented too rigidly, then the care plan will become a less effective tool for patient engagement and care improvement.

- SNP Fulfillment of the Previous Year's MOC Goals: The BBA requires that as part of the annual evaluation and approval of the MOC, CMS take into account whether the plan fulfilled the previous year's goals. Anthem supports the ongoing tracking and reporting of MOC goals; however, we recommend CMS recognize that MOC goals are multi-year and often reflect treating different individuals or populations over time (so some goals become evergreen as new individuals are engaged). We also ask that requirements related to fulfillment of MOC goals are distinct from goals for quality performance, which are separate standards for SNPs. If these requirements do overlap, then we suggest that compliance with quality goals would meet the requirements for MOC goals.

- Establishing a Minimum Benchmark for Each Element of the SNP MOC: The BBA requires that CMS establish a minimum benchmark for each element of the MOC and only approve a C-SNP's MOC if each element of the model of care meets such minimum benchmark. Anthem encourages a standardized and transparent process related to the evaluation of MOCs; in particular, we would appreciate more clarity regarding how separate scoring of the four elements would be conducted, in contrast to the current system, before providing feedback as to whether the 50 percent minimum is an appropriate threshold. We request additional guidance from CMS, along with a comment period on that guidance, before a minimum benchmark percentage is finalized. CMS should also ensure that inter-rater-reliability meets the standards of other CMS programs and that plans are provided resources to understand any negative compliance decisions.

Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes (§ 422.514)

Recommendation Summary: Anthem supports the enrollment of full-benefit dual eligible beneficiaries into D-SNPs that meet new integration requirements. However, if CMS moves forward with its proposal to curtail D-SNP look-alikes, we encourage this policy change be implemented in such a way that minimizes beneficiary disruption and is informed by the nuances of state D-SNP policies.

Recommendation Detail: CMS states that it is concerned with D-SNP look-alike plans not meeting standards for meaningful integration, particularly in light of additional requirements for D-SNPs starting in 2021 that are designed to ensure coordinated care between Medicare and Medicaid. As a result of

this concern, CMS is proposing, starting in 2022, not to enter into or renew contracts for an MA plan for an upcoming plan year when that plan is identified as exceeding a specific enrollment threshold (80 percent) for dually eligible individuals. MA organizations with plans identified as exceeding the enrollment threshold that also have approved D-SNPs for the following plan year, would be permitted to transition dually eligible beneficiaries from D-SNP look-alikes to D-SNPs for which the individuals are eligible. Given the significant impact this proposal would have on beneficiaries and plans, as outlined below, we request CMS finalize this policy well before bids are due.

Anthem supports CMS' efforts to encourage D-SNP integration, including the flexibility it has provided states to implement these requirements in ways that are most appropriate for each state. We encourage CMS to implement its proposal regarding D-SNP look-alikes with similar sensitivity to the nuances of different state requirements and market dynamics. Specifically, we support CMS' proposal to continue to allow D-SNP look-alike plans in states where D-SNPs or other integrated plans currently do not operate—in these states, D-SNP look-alikes provide valuable extra benefits to dual eligible beneficiaries that would not be available under a traditional MA benefit design.

We also request CMS not just allow for look-alike plans in states where D-SNPs do not operate, but also in counties or local markets where D-SNPs do not exist. We are aware of several instances where the state may allow for new D-SNPs, but the creation of a D-SNP is restricted at the market or county level (for example, we currently do not know which plans will be allowed to offer D-SNPs in certain California markets for 2021), and we do not believe CMS should close plans where either state or county policies prohibit that plan sponsor from creating a D-SNP that meets the necessary integration requirements. Therefore, we request CMS provide exemptions when state or local requirements are contradictory to its proposal.

Regarding CMS' proposed exception to its look-alike policy for new plans (plans that have been active for less than one year) with low enrollment, we encourage CMS to raise the enrollment minimum from 200 enrollees to 500 enrollees. This would better align with the enrollment levels already required for plan viability for Prescription Drug Plans (PDPs). Aligning these standards would create policy consistency and reduce administrative burden.

We also request CMS clarify that its 80 percent threshold applies only to full-benefit duals. As partial benefit duals do not receive full Medicaid benefits, and thus have less of a need for integrated benefits and services (and are rarely the target of states' integration efforts), we do not believe the enrollment of these individuals in D-SNP look-alikes is detrimental. In fact, the presence of D-SNP look-alikes may provide additional benefit choices that better meet beneficiaries' needs. And given the potential disruption to a number of beneficiaries currently in high-performing, five star look-alike plans that contain over 80 percent dual eligibles, we believe that keeping the threshold at 80 percent (or higher) and applying it only to full-benefit dual eligibles will help ensure that beneficiaries' care is not negatively impacted, choice remains, and confusion is minimalized (since a lower threshold would negatively impact even more beneficiaries currently in high-performing plans).

Regarding CMS' proposal to accommodate beneficiaries in terminated look-alike plans by transitioning their enrollment to a D-SNP or another zero-premium plan offered by the MA organization, the agency seeks comment on whether additional criteria for the plans accepting beneficiaries from terminated plans are necessary. We recommend CMS allow for an opt-out process for impacted beneficiaries to preserve beneficiary choice. Also, for terminated beneficiaries, we encourage CMS to consider the implications of this transition policy where the beneficiary is enrolled in a Medicaid plan that is

sponsored by the same organization as the D-SNP look-alike plan. We believe it would be detrimental to make that beneficiary have to choose unaligned coverage or be forced to also change their Medicaid carrier as a result of this policy. Such a disruption in ongoing care plans and care teams at the *individual level* is likely to outweigh any additional benefit from the D-SNP integration requirements at the *plan level*. Thus, we recommend that affected beneficiaries be permitted to stay with a MA plan or MAO, ensuring continued integration of their Medicare and Medicaid benefits.

Additionally, we encourage CMS to allow at least an additional year (until 2023) to implement this transition policy if finalized. As plans work to enter into agreements with states and implement compliant integrated D-SNP products to transition beneficiaries into (so as to avoid disruption in their care), we do not believe the timing between the finalization of this rule and the 2022 proposed start date for this policy change will be sufficient in all instances. If plans have not already submitted an application for a D-SNP, they will not be able to transition impacted beneficiaries for 2021, as required under this proposal. Additionally, as stated above, some states have not yet clarified which plans will be allowed to offer D-SNPs in specific markets for 2021. And since all D-SNPs currently must have executed contracts with applicable state Medicaid agencies, we request CMS also allow for subcontracts through a directly contracted entity in order to ease transitions for beneficiaries into the most integrated plan possible. If CMS will not allow at least an additional year for implementation, we ask CMS to allow for continuation of certain plans for the 2022 plan year where the MAO can demonstrate a good faith effort to apply for and implement a compliant D-SNP product.

We also request CMS clarify what data source it will use to determine the percentage of dual eligible beneficiaries in a plan, since plans would subsequently need to ensure these beneficiaries are eligible for a D-SNP (as well as what type of D-SNPs, such as a FIDE-SNP or HIDE-SNP). After plans have determined beneficiaries' dual status level, we would need to develop Annual Notice of Changes (ANOCs) that clearly explain to the beneficiary both how and why they are transitioning to a new plan—therefore, we also request CMS assist in providing guidance for providers and beneficiaries as to why this transition is occurring to prevent confusion.

B. Implementation of Several Opioid Provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act

Mandatory Drug Management Programs (DMPs) (§ 423.153)

Recommendation Summary: Anthem supports CMS' efforts to implement DMPs across Part D. We have successfully implemented our program, and believe these programs are effective tools to prevent and reduce beneficiary harm. We request guidance that provides clarity around the identification of potentially at-risk beneficiaries and consistent lookback periods and exemption criteria for beneficiaries receiving long-term or end-of-life care.

Recommendation Detail: The SUPPORT Act made changes to the requirements for Part D DMPs intending to enhance Part D sponsors' ability to reduce the abuse or misuse of opioid medications in prescription drug benefit plans. CMS is proposing to require Part D sponsors to adopt DMPs starting on or after January 1, 2022.

Anthem was an early adopter of the DMP program requirements, having implemented a successful program in2019. We believe these programs are an important and necessary tool to combat the opioid epidemic. As CMS takes steps to make these programs mandatory starting in 2022, we ask that the

agency provide more clarity and guidance around the requirements of the DMPs, particularly related to the specific criteria for identifying potentially at-risk beneficiaries.

Consistent measure criteria across programs, including the alignment of the Opioid Drug Management Program (ODMP) definitions, are needed to achieve positive outcomes. For example, CMS typically requires a 6-month lookback to define a beneficiary with a history of an opioid-related overdose. However, in the Advance Notice CMS proposed no lookback period for the Initial Opioid Prescribing (IOP) Measures for Part D.[7] Such inconsistencies negatively impact the implementation of the ODMP. In addition, exemptions should consistently include beneficiaries residing in long-term care setting or receiving palliative/end-of-life care, consistent with the DMPs.

Furthermore, with the addition of beneficiaries at-risk of opioid abuse to Medication Therapy Management Programs (MTMPs), we ask CMS to confirm expectations around At-Risk Beneficiaries (ARBs) in annual reporting. We would appreciate further harmonization of the clarification of potential modifications to reporting elements moving forward.

Beneficiaries with History of Opioid-Related Overdose Included in Drug Management Programs (DMPs) (§ 423.100)

Recommendation Summary: Anthem supports the inclusion of beneficiaries with history of an opioid-related overdose in plan DMPs. CMS should ensure alignment with the ODMP definitions, timelines, and exemptions as it implements this requirement.

Recommendation Detail: CMS is proposing to modify the definition of a potential at-risk beneficiary to include a Part D eligible individual who is identified as having a "history of an opioid-related overdose"—defined as a beneficiary with a recent claim containing the principal diagnosis code for an opioid overdose, regardless of the type of opioid, and at least one recent Prescription Drug Event (PDE) for an opioid dispensed to the beneficiary. Specifically, CMS proposes the following criteria:

- Diagnoses that include both prescription and illicit opioid overdoses;
- A 12-month lookback period from the end of each Overutilization Monitoring System (OMS) reporting quarter, for record of an opioid-related overdose within FFS claims and MA encounter data (excluding those not enrolled in a Part D plan, whether an MA-PD or standalone PDP plan); and,
- A 6-month lookback period from the end of each OMS reporting quarter, for record of a recent Part D opioid PDE.

Anthem recommends that CMS make every effort to align the inclusion criteria used to identify those with a history of opioid-related overdose with the standardized reporting of ODMP. For example, reconciling the definitions of negative opioid history versus someone who is opioid naïve. Without this alignment, conflicting definitions will inhibit reliable outcomes.

[7] CMS. "Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter." April 1, 2019. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf.

We also seek additional clarification on CMS' expectations for reviewing the cases of beneficiaries under this classification. Anthem believes someone with an overdose history should be regularly reviewed, and such a review is already part of our ongoing efforts. As such, we do not think a review needs to be part of the DMP process as it would be duplicative to existing efforts. We seek additional guidance on aligned exemptions, timeframes, and qualifying criteria, if such reviews are implemented as a requirement.

We appreciate CMS' acknowledgment that providers are integral to the process of communicating potential safety concerns to beneficiaries with a history of an opioid-related overdose. In addition to providing updated model notices, we encourage the agency to help communicate these changes to providers and beneficiaries to improve education and understanding around DMP changes.

Information on the Safe Disposal of Prescription Drugs (§ 422.111)

Recommendation Summary: Anthem appreciates the need to provide information to beneficiaries regarding the safe disposal of prescription drugs and encourages CMS to require the same notices to be communicated to Medicare beneficiaries by prescribers and pharmacies.

Recommendation Detail: The SUPPORT Act requires CMS to establish criteria for the information provided to an individual during an in-home HRA to ensure that each individual is sufficiently educated on the safe disposal of prescription drugs that are controlled substances. Anthem appreciates the need for CMS to implement this statutory requirement, and we are prepared to provide this information to our beneficiaries as part of our in-home HRAs.

We also believe this information could be effectively delivered to the beneficiary at the point they are given the prescription and/or when they fill the prescription. At these times, information on safe disposal is more likely to be understood, and the drugs are more likely to be disposed of safely as part of the beneficiary's care routine (e.g., expired medications can be disposed of at or near the same location where a new prescription is filled).

In model materials, CMS should include ways to identify local resources for disposing of unused/ unwanted drugs. For example, the Food and Drug Administration (FDA) provides consumer-friendly instructions on the safe disposal of unused medicines.[8] In addition, the U.S. Department of Justice provides a database to search controlled substance public disposal locations by zip code, city, or state.[9] Plans, prescribers, and pharmacists should provide information on resources to help beneficiaries identify locations to safely dispose of prescription drugs.

Beneficiaries' Education on Opioid Risks and Alternative Treatments (§ 423.128)

Recommendation Summary: Anthem supports the proposed flexibility for plan sponsors to target a subset of beneficiaries who would benefit most from information on opioid risks and alternative

[8] FDA. "Disposal of Unused Medicines: What You Should Know." Accessed March 18, 2020. https://www.fda.gov/drugs/safe-disposal-medicines/disposal-unused-medicines-what-you-should-know.

[9] U.S. Department of Justice. "Controlled Substance Public Disposal Locations - Search Utility." Accessed March 18, 2020. https://apps2.deadiversion.usdoj.gov/pubdispsearch/spring/main;jsessionid=lcHVs66J-ZlxHw0aFkA2BrLCEWm0o7cLJBWEKJNY.web2?execution=e1s1.

treatments. We request more specific guidance on the information Part D sponsors of MA-PDs will be required to provide to each beneficiary annually.

Recommendation Detail: Starting in 2021, the SUPPORT Act requires Part D sponsors to disclose to each beneficiary information about the risks of prolonged opioid use when used for the treatment of pain. In addition to this information, MA-PD sponsors must disclose coverage of non-pharmacological therapies, devices, and non-opioid medications under their plans. Sponsors of standalone PDPs must disclose coverage of non-pharmacological therapies, devices, and non-opioid medications under their plans and under Medicare Parts A and B. The SUPPORT Act also permits Part D sponsors of MA-PDs to disclose opioid risk and alternative treatment coverage information to only a subset of plan beneficiaries.

Anthem appreciates the proposed flexibility CMS has suggested for implementation of this provision; we also appreciate the additional information CMS provided in the proposed rule regarding possible subsets of beneficiaries plan sponsors could target. Finally, we appreciate the ability to provide this information as a separate, distinct beneficiary outreach mailing as this will reduce the burden of having to modify other standard materials or issue the standard materials in multiple versions.

We request more information about what must be provided to each beneficiary annually. While CMS has many helpful resources on the pain management website, each beneficiary must receive information in a standardized form for the treatment of pain, the risks associated with prolonged opioid use, and coverage of alternative therapies. We support the dissemination of clear model materials and/or examples to help Part D sponsors of MA-PDs comply with the new requirement.

Eligibility for Medication Therapy Management Programs (MTMPs) (§ 423.153)

Recommendation Summary: MTMPs provide demonstrated value to beneficiaries who have multiple chronic conditions, are on numerous medications, and are expected to incur high prescription drug costs for the year. While ARBs, or beneficiaries' determined to be at-risk for misuse or abuse frequently abused drugs, may benefit from some MTMP elements (many already qualify under existing criteria), still many other ARBs are distinctly different from the current MTMP population. Thus, we recommend CMS not require the inclusion of all ARBs into MTMPs, but rather enable plans to incorporate ARB status as a factor (in conjunction with other criteria) to target MTMPs better.

Recommendation Detail: The SUPPORT Act modifies MTMP requirements for Medicare Part D plans beginning January 1, 2021, by expanding the population of beneficiaries who are targeted for MTMP enrollment to include ARBs, and by adding a new service component requirement for all targeted recipients. We are concerned that COVID-19 will make the numerous proposed changes to the MTMP challenging to implement. In an environment where resources, time, and expertise are directed to support the COVID-19 public health crisis, we encourage CMS to delay implementation of the new requirements.

First, Anthem agrees with CMS that for many ARBs, Part D MTMPs can provide another tool to address opioid misuse. While DMPs primarily involve a prescriber-centric approach through case management to promote safer use of opioids and benzodiazepines, MTMPs leverage a beneficiary-centric approach to improve a beneficiary's medication use and reduce the risk of adverse events involving all medications (including opioids and other Frequently Abused Drugs). MTMPS and DMPs require different elements in order to produce positive outcomes for members, including case management and member engagement. Each program should be designed to serve a tailored population in order to best address

members' needs. While the programs create different approaches to mitigate misuse, we are concerned that without added clinical benefits, i.e. official medical reviews, DMPs and MTMPs will create duplicative efforts that may obstruct the intended solutions. We encourage CMS to enable MAOs to define ARBs to provide benefits beyond current DMP efforts to ensure at-risk beneficiaries are not overlooked.

Second, under existing criteria, many ARBs are already being targeted for MTMPs, but instead of requiring all ARBs to be targeted for inclusion for MTMPs, we ask that CMS allow plans to use ARB status as one factor, among others, to determine targeting for an MTMP. This flexibility will enable the industry, in partnership with CMS, to properly update all of the necessary standard materials and operationalize processes, including allowing MAOs to study the impact of MTMP services and create innovative programs to define clinical outcome goals better. Additionally, Anthem has other programs in place that are specific to ARBs outside of the DMP process.

Third, CMS inquires about the value of encouraging Part D MTM providers to use Fast Healthcare Interoperability Resources-enabled platforms when providing MTM to Part D beneficiaries to facilitate the integration of the service elements into prescribers' Electronic Health Records (EHRs). While Anthem understands the long-term potential of this approach, we see current deficiencies in EHR standardization and interoperability that create barriers to implementation. We would appreciate a standardized data exchange, within the proposed standardized format to further streamline data exchanges. Because Anthem is investing in these types of technologies and capabilities, we welcome continued opportunities to provide technical feedback on this type of approach as policy proposals move forward.

Fourth, regarding CMS' proposal to provide safe disposal information through MTM programs, we would reiterate our comments above: that while Anthem is capable of providing this information and more communication around safe disposal sites is valuable, prescribers and pharmacies are also in a position to provide beneficiaries with information that is relevant and more likely to be acted upon given providers' knowledge of local resources. We encourage CMS to leverage model language in the MTM welcome letter to ensure beneficiaries have access to more specific, localized resources to dispose of drugs safely.

Finally, we note that CMS is proposing a new standardized format for the Comprehensive Medication Review (CMR) as the completion rate is critical for Star Ratings, CMS should account for the operational challenges of implementing this change. CMS should also study the effects of CMR completion rates on MTMPs. We have noted diminishing returns as more beneficiaries have received reviews. While Anthem supports the updating of these materials, we are concerned about the timing of these requirements in conjunction with the new proposed requirements related to ARBs. We ask CMS to provide MAOs with more time to implement and test proposed changes by implementing the proposals in 2022.

Suspension of Pharmacy Payments Pending Investigations of Credible Allegations of Fraud and Program Integrity Transparency Measures (§§ 405.370, 422.500, 422.503, 423.4, 423.504, and 455.2)

Inappropriate Prescribing of Opioids

Recommendation Summary: We recommend CMS align this definition with existing regulations and guidance, including exclusions for long-term care, palliative care, and end-of-life care.

Recommendation Detail: To implement SUPPORT Act requirements around communication on over-prescribers, CMS proposes a definition for inappropriate prescribing. We encourage CMS to work to align this definition with existing regulations and guidance, including those related to PDMPs. Specifically, this would include exceptions for situations such as long-term care, palliative care, and end-of-life care, and other alignments as appropriate.

C. Implementation of Certain Provisions of the 21st Century Cures Act

Medicare Advantage (MA) Plan Options for End-Stage Renal Disease (ESRD) Beneficiaries (§§ 422.50, 422.52, and 422.110)

Recommendation Summary: In 2021, as directed by the 21st Century Cures Act, all ESRD patients will be eligible to enroll in MA. This new policy will lower OOP costs for ESRD beneficiaries and expand access to new supplemental benefits to address drivers of health, including care coordination services not available in FFS. Additionally, the Administration's Advancing Kidney Health in America initiative creates new opportunities to improve the lives of Americans suffering from kidney disease. We are prepared to support the goals of this initiative, as well as the changes of the 21st Century Cures Act, by managing the specialized care associated with ESRD patients.

Given the significant changes brought about by the 21st Century Cures Act, and our collective desire for successful implementation, it is important that CMS address several long-standing policy concerns associated with expanding access to MA for individuals with ESRD. These concerns include improving MA ESRD payment accuracy by adjusting the benchmarks to account for the MOOP limit required in MA and moving away from a statewide benchmark for payment.

Furthermore, we recommend that the Administration allow MA plans to participate in the CMMI kidney models and expand the list of C-SNP conditions to include patients with CKD, to expand ESRD beneficiaries' access to value-based plan designs.

Recommendation Detail: We are eager to collaborate with CMS to increase high-quality plan options for ESRD beneficiaries in 2021. However, if concerns around benchmark accuracy and barriers to care are not addressed, all MA beneficiaries, not only those with ESRD, would face increased premiums, reduced benefits, and fewer plan options.

Benchmark Accuracy and Bid Process

The ESRD benchmarks in MA are based on Medicare Parts A and B FFS costs. For beneficiaries with ESRD, MA plans are required to cover the same services offered in FFS, but currently MA beneficiaries' OOP costs cannot exceed more than $6,700 a year. This makes OOP financial protection in MA different from FFS, where there is no OOP limit. This is a crucial difference, given that today, the average FFS annual OOP responsibility for individuals with ESRD is $13,000.[10]

[10] Health Management Associates. "End-Stage Renal Disease and Medicare Advantage." February 12, 2019. https://www.healthmanagement.com/wp-content/uploads/Health-Management-Associates-ESRD-and-Medicare-Advantage-White-Paper.pdf.

The MA ESRD benchmarks do not take into consideration the cost of the mandatory MOOP limit in MA. As a result, these benchmarks do not accurately anticipate the costs of treating ESRD patients. The mandatory MOOP will increase MA costs by approximately 8-9 percent compared to FFS spending (and benchmarks).[11] As a result, to make up for this payment shortfall for ESRD beneficiaries, analysis shows beneficiary premiums in MA could increase by as much as $18, or benefits could be cut by a similar magnitude if CMS does not address payment inadequacies for beneficiaries with ESRD.[12] Therefore, CMS should incorporate the $6,300 difference between the FFS OOP spending and the MA MOOP as part of its estimates in the MA benchmarks.[13]

While CMS has proposed adjusting the methodology for setting the MOOP limits to take into account the removal of restrictions on beneficiaries with ESRD allowed to enroll in MA plans beginning in 2021, we are concerned the proposal does not do enough to keep program costs low for beneficiaries'. CMS' proposal would create a new third MOOP limit – referred to in the Proposed Rule as the "intermediate" MOOP limit – set in-between the existing mandatory MOOP limit and the "lower" (or "voluntary") MOOP limit. In addition, CMS would phase-in additional costs incurred by beneficiaries with ESRD into the MOOP limit calculation over time. Therefore, the agencies proposal would increase costs for all beneficiaries'.

In addition, we encourage CMS to consider the significant variation in spending that exists for ESRD patients across metropolitan areas in a single state. CMS pays MA plans a statewide benchmark for ESRD beneficiaries, based on FFS costs. However, data from California, Florida, Ohio, and Texas reveal that metropolitan areas in the same state can be significantly above or below the overall state average. These metropolitan areas also show significant volatility in their averages over a three-year period.[14] CMS should model the implications of setting ESRD rates at the metropolitan level, rather than the state level, and allow stakeholder comment on a new approach to setting ESRD benchmarks at a smaller geographic level to achieve more accurate payment for ESRD beneficiaries.

Improve Prevention and Address Clinical Barriers

Studies have found that C-SNPs achieve better outcomes by providing targeted care to address beneficiaries' chronic conditions.[15, 16] Today, while C-SNPs serve ESRD patients, they are not able to serve patients with CKD who have not yet progressed to ESRD. The care coordination offered by MA plans could help patients with CKD better manage their disease and delay, or even avoid the progression

[11] Health Management Associates. "End-Stage Renal Disease and Medicare Advantage." February 12, 2019. https://www.healthmanagement.com/wp-content/uploads/Health-Management-Associates-ESRD-and-Medicare-Advantage-White-Paper.pdf.

[12] Wakely. "2021 Medicare Advantage Advance Notice." March 4, 2020. https://www.ahip.org/wp-content/uploads/CY2021-Advance-Notice-Summary-and-Analysis-03-04-2020.pdf.

[13] $6,300 was determined based on subtracting the MA's MOOP of $6,700 from the average OOP cost for a FFS ESRD beneficiary of $13,000.

[14] Health Management Associates. "End-Stage Renal Disease and Medicare Advantage." February 12, 2019. https://www.healthmanagement.com/wp-content/uploads/Health-Management-Associates-ESRD-and-Medicare-Advantage-White-Paper.pdf.

[15] Avalere Health. "Effects of Chronic Condition Special Needs Plan Enrollment on Outcomes for Medicare Beneficiaries with Diabetes." October 2017. https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19n/mziw/~edisp/pw_g320739.pdf.

[16] Health Affairs. "Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use among Diabetes Patients." January 2012. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0998.

of their condition to ESRD. Therefore, we encourage CMS to expand the list of C-SNP conditions to include patients with CKD.

In addition, consistent with the Administration's Advancing American Kidney Health initiative, CMS should provide MAOs with the option of participating in the CMMI kidney models to improve the dissemination of best practices in kidney care. With a focus on care coordination and whole person health, Anthem is well-positioned to participate in these programs and achieve the goals of improving CKD management, lowering the incidence of patients progressing to ESRD, increasing ESRD home care, and increasing kidney transplant opportunities through value-based payment arrangements.

Medicare Fee-for-Service (FFS) Coverage of Costs for Kidney Acquisitions for Medicare Advantage (MA) Beneficiaries (§ 422.322) and Exclusion of Kidney Acquisition Costs from Medicare Advantage (MA) Benchmarks (§§ 422.258 and 422.306)

Recommendation Summary: Anthem is concerned CMS' estimate of kidney acquisition costs does not accurately reflect the costs for MAOs. As additional analysis has shown, CMS' current estimate appears to be inflated.[17] We encourage CMS to re-evaluate the estimate of kidney acquisition costs and make the methodology to estimate the kidney acquisition costs more transparent, while considering MAOs' data and actual experience before removing $4 PMPM from the MA benchmarks.

Recommendation Detail: Anthem is concerned about payment accuracy for ESRD beneficiaries in MA, particularly with regard to CMS' estimate of kidney acquisition costs. Beginning in 2021, the 21st Century Cures Act allows all ESRD beneficiaries to join MA and excludes organ acquisition costs for kidney transplants for MA beneficiaries from payment benchmarks, with such costs covered by FFS. CMS estimates a weighted average reduction of about $4 PMPM from the MA ESRD state rates. Based on Anthem's internal analysis, we are concerned CMS is overestimating the impact of excluding kidney acquisition costs from the benchmark, since we interpret the new rule as requiring MAOs to continue to be responsible for the costs associated with the transplant procedure and subsequent medical care.

While CMS provides helpful detail regarding the steps it will take to exclude kidney acquisition costs from MA benchmarks, we ask the agency to release the underlying cost and discharge data to make the methodology more transparent. We are concerned there may be misalignment between the number of Medicare discharges as reported in the cost reports and the number of Medicare inpatient stays as reported in the claims data. This misalignment may be inflating the total estimated organ acquisition costs.

In addition, we ask that CMS consider MAOs' data and actual experience with kidney acquisition costs, which Anthem estimates to vary by state, and be substantially lower than $4 PMPM. This may be influenced by our interpretation of CMS' calculation of these costs, which reinforces the need for specific detail and further guidance. The discrepancy may also reflect the volatility of the costs of care for this patient population. Because CMS' FFS data includes a greater proportion of kidney transplant patients compared to individual MAOs, we are concerned about the disproportionate impact the $4 PMPM reduction will have on benefits with minimal or no claims reductions to offset this revenue loss.

[17] Wakely. "2021 Medicare Advantage Advance Notice." March 4, 2020. https://www.ahip.org/wp-content/uploads/CY2021-Advance-Notice-Summary-and-Analysis-03-04-2020.pdf.

D. Enhancements to the Part C and D Programs

Reinsurance Exceptions (§ 422.3)

Recommendation Summary: Anthem appreciates CMS' concern that overly generous reinsurance can lead to moral hazard; however, we believe the proposed rule does not accommodate the different uses of reinsurance, or explicitly grant exceptions where the reinsurer and MAO are owned by a common parent. We instead recommend a minimum standard of 10 percent risk assumption where the MAO obtains reinsurance from an affiliate and/or a joint venture or alliance partner.

Recommendation Detail: CMS proposes that an MAO may obtain reinsurance or make other arrangements for the cost of providing basic benefits if the aggregate value of such an arrangement exceeds a $10,000 aggregate per individual (or the first-dollar equivalent).

While Anthem appreciates CMS' desire to balance risk-assumption with potential moral hazard, we would like to make the Administration aware of situations where reinsurance is used for the purpose of allocating risk among participants in an MA venture or alliance. For example, a local plan may wish to pair its market knowledge with the operational expertise of a larger player. The two organizations take on the joint responsibility to administer the product, and use a reinsurance agreement as a mechanism to allocate the proportional profits/losses of the venture or alliance – related to the stake in the venture or alliance.

These types of arrangements can lead to better products for beneficiaries that are higher-quality, have lower administrative costs, and are more tailored to local demands than either participant could do independently. To this end, we believe CMS' proposal is overly broad in its application to reinsurance, and would have unintended consequences by eliminating arrangements designed as profit share distribution mechanisms between participants in the venture or alliance.

In order to accommodate the multiple uses of reinsurance in the business of MA, we propose adopting an alternative standard: an MAO may obtain insurance, reinsurance or make other arrangements for the cost of providing basic benefits to an individual beneficiary that either the aggregate value of which exceeds an aggregate level that is greater than or equal to $10,000 during a contract year or through quota share reinsurance on a first dollar proportional basis, where the MA organization or an affiliate of the MA organization retains a minimum 10 percent quota share percentage of the risks being transferred.

We urge CMS to make accommodations in its proposed regulation for situations where an MAO obtains reinsurance from an affiliate and/or a joint venture or alliance partner. As noted earlier, because reinsurance is a useful means by which to share profits/losses in joint ventures and alliances, an entity may choose to allocate its risk to a reinsurer that is an affiliate of the MAO, and to another joint venture or alliance partner. Again, such arrangements are not about the abdication of risk, but rather serve as a mechanism to facilitate the allocation of profits/losses under the joint venture or alliance.

Out-of-Network Telehealth at Plan Option

Recommendation Summary: Anthem supports CMS' proposal to expand the use of out-of-network telehealth which would allow these services to be covered as a basic benefit.

Recommendation Detail: CMS is considering permitting Additional Telehealth Benefits (ATBs) to be provided by non-contracted providers as a basic benefit in cases where the non-contracted providers satisfy ATB requirements set forth in previously finalized MA regulations.

Anthem supports this flexibility because we believe that out-of-network providers will be able to meet the existing requirements and having telehealth access to more providers in the basic benefit will create additional resources for beneficiaries to get timely and appropriate care. This could be especially valuable where there is a strain on local health care resources resulting from a spike in COVID-19 across a community.

Referral/Finder's Fees (§§ 422.2274 and 423.2274)

Recommendation Summary: Anthem views referrals and enrollment as different activities and thus we recommend CMS consider payment for these activities separately. Therefore, instead of bundling referral fees within the definition of Fair Market Value (FMV), we propose the agency allow for reasonable referral and enrollment fees separate and apart from FMV.

Recommendation Detail: CMS seeks to clarify that compensation is on a per-enrollment basis. Since referral fees are part of compensation, organizations may not pay independent agents more than regulatory limits. Because referral fees are already incorporated into compensation, CMS believes limiting the amount of a referral fee has no impact on the statutory requirement of an agent enrolling a beneficiary in the plan that best meets their healthcare needs. However, in our experience the referring agent is often different than the agent or broker who enrolls the beneficiary. Therefore, we would like to handle the referral and enrollment fees separately, and recommend CMS address payment for these activities separately

Medicare Advantage (MA) and Part D Prescription Drug Program Quality Rating System (§§ 422.162, 422.164, 422.166, 422.252, 423.182, 423.184, and 423.186)

As detailed below, Anthem has specific recommendations related to 1) measure-level star ratings, 2) adding, updating and removing measures, 3) measure weights, and 4) extreme and uncontrollable circumstances. Overarching all of our comments is a request for flexibility and accommodations related to the ramifications of the ongoing COVID-19 pandemic.

Necessary changes in how we provide beneficiaries with access to care during this time—as well as in requests to our provider partners—will require changes to the Star Ratings program in response. For instance, in the short-term, we encourage CMS to ensure health plans are not encouraging beneficiaries or providers to conduct activities counterproductive to combating COVID-19 such as chart collection, calling to encourage beneficiaries to seek preventive care, and delivery of routine care or non-emergency related screening. At the same time, plans and providers should be encouraging beneficiaries to use telehealth for non-emergency consultation with a provider. As a result, and given that the duration of the public health emergency remains uncertain, larger policy changes and

modifications to the Star Ratings will be necessary as quality measures will be incomplete for 2021 Star Ratings (HEDIS and CAHPS) and 2022 Star Ratings (all measures).

Measure-Level Star Ratings (§§ 422.166(a), 423.186(a))

Recommendation Summary: Instead of removing outliers, Anthem strongly recommends that CMS restore the predetermined thresholds as they provide valuable stability and enable plans to track and achieve known targets over time.

Recommendation Detail: CMS is proposing to remove outlier values via the Tukey outer fence methodology. While Anthem appreciates CMS' focus on providing more stability to the cut points from year-to-year, we believe the best approach to achieve that goal is to return to the previous CMS policy of predetermined thresholds.

Given the significance of the Star Ratings on beneficiary enrollment decisions and plan payment, Anthem continues to believe that sponsors need better information to benchmark performance and focus improvement efforts. Specifically, we recommend that CMS reinstate predetermined 4-Star thresholds. We valued the stability that predetermined thresholds provided and used them as benchmarks to track achievement. We also found the thresholds helpful in setting quality expectations and performance targets jointly with providers to track improvements and design value-based payment arrangements.

If CMS chooses not to reinstate the predetermined 4-Star thresholds, we have concerns with CMS' proposed outlier removal approach. Removing outliers is a statistical approach that is typically employed where there is reason to believe that the outlier values are somehow invalid—for example data entry errors, sampling problems, or measurement issues. Our understanding is that current integrity monitoring should account for these types of issues, so that outliers in the existing star ratings reflect natural variation. We are concerned the approach could further cluster cut points, inaccurately pulling cut points down. Furthermore, one study found it was not possible to replicate CMS' cut point calculations because the agency excludes some contracts' Stars measure data from the published data set. If the goal is to create more cut point stability then using fixed thresholds is a simpler and more transparent approach.[18]

Adding, Updating and Removing Measures (§§ 422.164, 423.184)

Recommendation Summary: Anthem's recommendations on adding, updating, and removing the proposed Star Ratings measures are as follows:

- Rheumatoid Arthritis Management Measure: We support the removal of the Rheumatoid Arthritis Management measure.
- SUPD Measure: We support the categorization of the SUPD measure as a process measure with clinically appropriate exclusions, retaining a weight of 1 for the Star Ratings and Improvement Measures.
- HOS Measures: We encourage CMS not to field the HOS due to COVID-19 as we are concerned beneficiaries should not be asked to respond to surveys at this time. CMS should recognize that the HOS baseline will be significantly impacted by the pandemic, and results should be rated

[18] Wakely. "Proposed Rule Changes to the Medicare Star Rating Program." March 20, 2020.

N/A through at least 2023. In addition, we do not believe the Improving or Maintaining Physical Health (PCS) measure and Improving or Maintaining Mental Health (MCS) measures should continue to be part of the Star Ratings unless modifications produce year-over-year consistency and reliability.

- HEDIS Transitions of Care Measure: We are concerned the Transitions of Care measure in its current form is counter-productive to improving the quality of care transitions from the inpatient setting to the home. We encourage CMS to ensure the measure indicators include all providers who can appropriately support a beneficiary during a care transition, support transition programs that do not require that a beneficiary have a Primary Care Provider (PCP) visit, and provide measure flexibility due to privacy and administrative limitations.
- Emergency Department (ED) Follow-up Measure: We encourage CMS to delay the inclusion of the Follow-up after ED Visits for Patients with Multiple Chronic Conditions measure for an additional two years in order to improve the measure accuracy regarding the transition to home, particularly given the challenges related to the increase in ED visits for COVID-19.
- SNP Care Management Measure: We ask that CMS modify the SNP Care Management measure calculation to better align with compliance standards.

Recommendation Detail:

- Rheumatoid Arthritis (RA) Management Measure: We support CMS' proposal to remove the Rheumatoid Arthritis Management measure from the Part C Star Ratings for the 2021 measurement year and the 2023 Star Ratings. This measure assesses whether patients 18 years and older with a diagnosis of RA were dispensed at least one Disease-Modifying Antirheumatic Drug (DMARD) during the measurement year.

  While we support the goal of aggressively treating RA to achieve clinical remission, minimize irreversible joint damage, preserve function, and improve long-term outcomes, this measure has low reliability. The measure denominator currently includes RA patients in remission without the use of DMARDs, patients who cannot tolerate DMARDs, and patients in clinical trials receiving sample medications. Furthermore, some patients can manage their RA through other medications, and the measure could force the unnecessary use of biologic disease modifying Antirheumatic drugs. Current NCQA HEDIS measure technical guidelines do not provide for medical exclusions, creating barriers for plans to continually improve performance and calling into question the validity of the measure as an indicator of quality care.

- HOS Measures: We encourage CMS to recognize the significant impact COVID-19 will have on the reliability of HOS results. The survey should not be fielded during the pandemic because beneficiaries should not be asked to complete routine surveys as this time. Given the disruption to the HOS we encourage the agency to rate the HOS baseline as N/A through 2023.

  CMS is proposing to change its case-mix adjustment methodology for two measures from the Medicare HOS: the PCS measure and MCS measure. CMS also proposes to increase the minimum required denominator from 30 to 100 for the two measures. Anthem appreciates CMS' efforts to update the HOS survey methodology to more accurately reflect the patient population. Nonetheless, we still have overarching concerns with these measures, and the use of survey measures in general. Unless these modifications lead to results with similar year-over-year reliability as other Star Ratings measures, we advise removing these measures entirely until such consistency can be validated.

We also question the usefulness and validity of having the PCS and MCS measures linked back to death probability rather than actual improved health. We see this as especially concerning where pandemics such as COVID-19 could affect mortality in the Medicare population—creating further instability and inconsistency in plan results.[19]

Furthermore, while Anthem agrees with CMS' assertion that "patients are the ultimate source of information on patient outcomes," we reiterate our serious concerns with the use of survey-based measures in the Star Ratings, which require beneficiary recall and rely on perception rather than data-driven evidence and outcomes. CMS notes the limitation of survey measures in its decision to retire the Osteoporosis Testing in Older Women (Part C) HOS measure for 2023 due to "concerns about the validity of this survey measure and the ability of women to accurately recall their screening history." We continue to believe that any measures contemplated by CMS for inclusion in the Star Ratings system should be based on objective clinical criteria.

As CMS considers the addition of new longitudinal measures from the HOS, we ask the agency to increase the survey's transparency, timeliness, relevance, and data stability. In addition, we would appreciate notification regarding which Anthem beneficiaries completed the HOS so that we may conduct a root causes analysis of any issues raised. Furthermore, there is a long lag time of approximately three years between when the survey begins and when we receive any survey results. We request more real-time data on patient outcomes, so the data can be better utilized for improvement purposes.

- SUPD Measure: While CMS finalized the SUPD measure with the intermediate outcome classification in the April 2019 final rule for the 2021 Star Ratings, the agency no longer believes this is the appropriate classification. Anthem agrees. For consistency, we recommend that CMS retain the SUPD measure's weight of 1 in the 2021 Star Ratings and Improvement Measures. There is wide agreement that the SUPD measure is a process measure, and no aspect of the measure is changing specifically for 2021. Increasing the SUPD measure to a weight of 3 for 2021 and decreasing it to a weight of 1 in future years would create confusion and inconsistency in the Star Ratings program.

  Additionally, we encourage CMS to ensure the measure calculation excludes patients for whom statin use may not be medically appropriate. The medical literature shows certain demographic groups are more likely to be predisposed to statin intolerance. Providers are less likely to prescribe or continue statin use for patients who have experienced diminished effectiveness or adverse effects from the drugs. We are concerned the measure could inaccurately represent prescribing behaviors that reflect patients' medical needs. Given the breadth of clinical concerns related to this measure, we urge CMS to allow medical exclusions for this measure.

- HEDIS Transitions of Care (TOC) Measure: CMS is proposing to add the HEDIS Transitions of Care and the HEDIS Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions measures to the 2023 Star Ratings covering the contract year 2021 Performance Period. Measuring the quality of care transitions is a complex and challenging process due to the

[19] William H. Rogers, Ph.D. et al. "Calculating Medicare Health Outcomes Survey Performance Measurement Results." February 2004. https://www.hosonline.org/globalassets/hos-online/publications/hos_calculating_pm_results.pdf.

number of providers and healthcare settings involved. Therefore, Anthem encourages CMS to ensure that the measure indicators include all providers who can appropriately support a beneficiary during a care transition and avoid limiting the measure to PCPs since patients with chronic care needs may be primarily managed by a specialist rather than a general practitioner. We also encourage the measures to accommodate virtual visits given COVID-19 and the expanded use and sophistication of telehealth in recent years.

In addition, MA plans often have programs in place (e.g., visiting nurses, or registered pharmacists who complete the medication reconciliation) to support the transitions home that do not necessarily require that a beneficiary have a PCP visit. These programs provide valuable supports and services to improve the quality of care transitions from an inpatient setting to home and should not be discounted or inadvertently discouraged as a result of this measure.

Furthermore, all component indicators that CMS lists must be satisfied to meet this contemplated measure. We are concerned that combining multiple data elements into one measure will not appropriately account for positive performance on any of the elements. For example, a plan may successfully complete the Medication Reconciliation Post-Discharge element of the measure, but may not be able to guarantee the appropriate documentation of admission and discharge dates in the PCP chart.

We are also concerned with the short timeframe to notify the PCP of an inpatient admission or discharge. Privacy and administrative limitations can prevent health plans from receiving communication that a beneficiary has transitioned from the hospital to their home. In addition, it is important for CMS to provide flexibility, particularly in the case of out-of-network and non-contracted facilities. We are concerned that the measure in its current form could be counter-productive to the ultimate goal of improving the quality of care transitions from an inpatient setting to home.

- ED Follow-up Measure: Anthem supports the concept of this measure, but we note the same concerns with this measure as the TOC measure, discussed directly above, and encourage additional flexibility for capturing follow-up visits. Methods for measuring the quality of transitions home should be validated for feasibility, appropriate methods, and best practices before implementation, particularly given the fact that COVID-19 cases are overwhelming EDs across the country. We are concerned about the accuracy of the methods being used to capture a transition into the home from the hospital and encourage the release of more data to ensure feasibility and reliability before 2021 measurement and 2023 Star Rating inclusion. Once the measure has been validated, it should be designated as a display page measure for another 2 years.

- SNP Care Management Measure: We request that CMS better align the SNP Care Management measure with compliance requirements. Specifically, the current measure does not make allowances for beneficiaries that cannot be reached, refuse to engage, or do not complete a HRA within the specified time. Subtracting these data elements that are already documented through compliance procedures would ensure appropriate data allowances are captured in the measurement calculation. These adjustments will not reduce beneficiary engagement as there is already a minimum number of telephonic outreaches that must be conducted to meet program standards. We encourage CMS to revise the measure formula to assess true compliance with all HRA requirements.

Medication Adherence Star Rating Measure Accuracy

Recommendation Summary: Patient safety and Star Ratings accuracy is compromised when a beneficiary obtains a medication without utilizing their prescription drug benefit, and their pharmacist does not file a claim. Anthem asks CMS to require a pharmacy claim submission process for cash payments, and permit MAOs to submit attestations that show the patient received their medication. This will address situations in which a beneficiary has an extended gap in their fill history, while other supplemental data shows the patient received their medication.

Patient safety issues arise when plans do not know a beneficiary has obtained a prescription medication. Therefore, in the long-term we recommend CMS develop a repository with pharmacy prescription records so that plans can better monitor prescribing and dispending patterns, and track the prescription medications beneficiaries obtain.

Recommendation Detail: The rising availability of free and low-cost generic prescription drugs from pharmacies, direct-to-consumer advertising, and drug discount programs, and the opioid epidemic have contributed to an increase in beneficiaries choosing not to present their prescription drug insurance card, and paying cash for medications. While we appreciate that CMS encourages the use of the Part D benefit, and requires beneficiaries who choose to make a cash purchase for covered Part D drugs to submit documentation to their plan, we have encountered several situations where appropriate claims documentation is not submitted. These situations negatively impact patient safety and the accuracy of Star Ratings data.

We are particularly concerned about patient safety when claims are not processed through the Part D benefit. In these situations, plans are unable to appropriately monitor safety issues such as drug interactions, opioid use, or duplicate therapies, if a beneficiary fills a cash prescription outside of their Part D benefit at a pharmacy to take advantage of a discount program. It is critical that plans are able to conduct concurrent drug utilization reviews to capture and track beneficiaries' medications to ensure patient safety.

Anthem supports efforts to increase medication adherence and patient safety, and also recognizes patients have a choice in how to pay for their medications. However, there are safety concerns when a beneficiary obtains a prescription from a pharmacy and the plan does not know what medication the beneficiary has obtained. To address this situation, we encourage CMS to require pharmacies to submit claims to Part D plans for all cash payments, and permit MAOs to submit attestations that shows the patient received their medication. In the long-term, we support the development of a registry of pharmacy records to boost oversite of prescribing and dispending to improve patient health and safety, and ensure accurate medication adherence Star Ratings scores.

MPF Price Measure Star Rating Accuracy

Recommendation Summary: We are concerned that specialty drug prices constantly fluctuate due to manufacturer pricing decisions, leading to large variances between drug costs at the POS and drug prices on the MPF. Beneficiaries' access to reliable drug pricing information and Star Ratings data depends on the accuracy of the MPF. Therefore, we request that CMS allow for corrections of specialty drug prices during the Star Ratings plan preview window to improve the accuracy of price information for beneficiaries and Star Ratings data.

Furthermore, we would like to work with CMS to increase the efficiency of the process for updating drug prices on the MPF. We also request that the agency consider an exceptions process to allow for larger price variances for high-dollar specialty drugs to hold plan Star Ratings harmless with proof a drug price has changed significantly over a two-week period.

Recommendation Detail: We request that CMS allow for corrections of specialty drug prices during the Star Ratings plan preview window to improve the accuracy of specialty drug price information for beneficiaries and Star Ratings quality data. Prices on brand name drugs change often at the manufacturer's discretion. These changes are not scheduled, and lead to price differences between the MPF and the POS. We encourage CMS to account for pharmaceutical market volatility and create allowances for updating the MPF should a drug have a rapid price swing, negatively impacting the accuracy of drug pricing information for beneficiaries and the MPF price measure data for Star Ratings.

In addition, we would like to work with CMS to increase the timeliness of the process for updating drug prices on the MPF. We are concerned that making drug price changes on the MPF can take two to four weeks, while specialty drug prices can change daily. This delay between the pricing at the POS and updates to the MPF cause higher dollar discrepancies for beneficiaries at the pharmacy counter.

As challenges ensuring the accuracy of the MPF are likely to persist, we request that the agency consider an exceptions process, similar to processes that already exist in the Part D program, to allow for larger price variances for high-dollar specialty drugs to hold plan Star Ratings harmless with proof a drug price has changed significantly over a two-week period. A 2019 AARP study found 267 widely used brand name prescription drugs increased by 5.8 percent, more than twice as fast as inflation in 2018.[20] In addition, the ratio of the increase in specialty drug prices compared to the inflation rate has increased over the past 10 years.[21] The high volume of price changes in the specialty drug market over the past decade necessitates a different process to ensure accurate MPF drug pricing data.

Measure Weights (§§ 422.166(e), 423.186(e))

Recommendation Summary: Anthem opposes increasing the weight of patient experience and complaint measures to 4, well above the weight of clinical outcomes measures. We are concerned about the unprecedented shift away from the objective clinical Star Ratings measures. Any change regarding the weight of the patient experience and complaint measures should be preceded by a critical evaluation of the CAHPS and HOS surveys given concerns about decreasing response rates, and the accuracy and reliability of survey results.

These concerns could be exacerbated this year as HOS vendors have been instructed by CMS to hold on any mailing of the surveys for 2020 given COVID-19, which could further decrease response rates impacting the accuracy and reliability of survey results. While we appreciate that the survey will be postponed until the summer, we are concerned about the long-term impact of the public health crisis on respondent's physical and mental health, and their perception of the health care system and health plans.

[20] AARP Public Policy Institute. "Brand Name Drug Prices Increase More than Twice as Fast as Inflation in 2018." November 2019. https://www.aarp.org/content/dam/aarp/ppi/2019/11/brand-name-drug-prices-increase-more-than-twice-as-fast-as-inflation.doi.10.26419-2Fppi.00073.005.pdf.

[21] Journal of Managed Care & Specialty Pharmacy. "Evaluation of Specialty Drug Price Trends Using Data from Retrospective Pharmacy Sales Transactions." September 22, 2016. https://www.jmcp.org/doi/full/10.18553/jmcp.2016.22.9.1010.

If CMS increases the weight of this measure without addressing these concerns, the Star Ratings could be inaccurate and mislead beneficiaries. We encourage CMS to continue to base the Star Ratings on a comprehensive, objective, quality review system. While we appreciate the importance of ensuring patients have a positive experience, and appropriate access to care, we encourage a slower and more thoughtful transition to increasing the weight of patient experience and complaint measures.

Recommendation Detail: CMS is proposing to increase the weight of patient experience/complaints and access measures to 4 after increasing the weights from 1.5 to 2 for the 2021 Star Ratings. We are concerned that such a change would represent a fundamental, unprecedented shift where CMS is moving the Star Ratings system away from objective clinical measures to subjective measures. As a result, beneficiary experience measures will increase from around a quarter, to half of Star Ratings measures creating a fundamental imbalance based on subjective results from a sample population of plan beneficiaries surveyed, which undermines the purpose of a comprehensive quality review system.

If CMS plans to increase the use of CAHPS and HOS, we encourage the agency to critically assess the accuracy and reliability of the surveys. Both surveys need to be modernized as response rates decline, and both beneficiaries and practitioners are suffering from survey fatigue (the surveys contain nearly 100 questions, many of which include unclear language). Additionally, operationalizing the surveys is challenging (there are only two CMS vendors that can deploy the surveys) and they have not kept pace with current survey methods and technologies. Furthermore, the transparency of the surveys could be improved as CMS does not make public the measure level response data among plans.

Lastly, the CAHPS and HOS measures should be removed from the improvement factor calculation because survey data are based on respondents' perceptions of their health status, that can change based on circumstances like COVID-19, and thus are not a true reflection of plan performance or beneficiaries' outcomes. If performed inconsistently, the improvement comparison will not be valid—further emphasizing the importance of excluding CAHPS and HOS measures from this calculation.
If CMS continues to use surveys, then we encourage CMS to survey beneficiaries throughout the year, rather than rely on a single survey that captures just one point in time. In addition, we ask CMS to inform plans of the beneficiaries they have surveyed so that we may reach out to conduct root cause analyses to address any issues they identified. We stand ready to partner with CMS to update the CAHPS and HOS surveys to improve the accuracy of the patient experience and complaint measures.

Extreme and Uncontrollable Circumstances (§§ 422.166(i), 423.186(i))

Reset Star Rating Program to Acknowledge Impacts of COVID-19

Recommendation Summary: While we appreciate CMS' proposals in the interim final rule to modify the calculation of the 2021 and 2022 Part C and D Star Ratings to address the disruption to data collection and measure scores, we are concerned the agencies proposals do not do enough to account for the full impact of the COVID-19 public health emergency on Star Ratings. We encourage the agency to make necessary changes to the 2021 and 2022 MA Star Ratings to enable plans to fully shift focus and attention to improving beneficiaries' care under these unique circumstances, and redeploy trusted resources to help members remain safely in their homes to help avoid the further spread of the virus.

We have altered our approach to ensuring our beneficiaries have access to care to comply with the CDC guidelines and the social distancing mandate to avoid large crowds. We recognize our previous focus on preventive and primary care would be counterproductive, and could lead to further spread of the virus

or take time away from emergent and urgent patient care. Therefore, we are focused on our beneficiaries' needs as they may have to self-isolate, quarantine, or shelter in place. In addition, we have shifted our efforts to ensure access to food, home care, and mail order and home delivered prescriptions, and we are encouraging beneficiaries to participate in programs to address potential depression, anxiety, or social isolation such as our Member Connect Phone Pal program.

Due to the COVID-19 pandemic, the 2021 and 2022 Star Ratings will not accurately measure the quality of MA and Part D plans across the country, and data will be incomplete at a minimum for 2021 and 2022 Star Ratings. We recommend that the agency does not calculate Stars for rating years 2021 and 2022, as is, and resets the Star Ratings program beginning with measurement period January 2021 for 2023 Star Ratings.

In the short-term, we recommend CMS provide the following immediate guidance on the Star Ratings to enable plans to focus interactions with beneficiaries and providers on the treatment and prevention of COVID-19:

- Suspend chart pulls for Healthcare Effectiveness Data and Information Set (HEDIS) measurements;
- Enable plans to shift focus from inquiries to providers as a basis for measuring Stars;
- Enable plans to cease outreach to beneficiaries for non-emergent care as a basis for measuring Stars.
- Account for the pandemic in the standard operational processes that may be impacted such as the Complaint Tracking Module (CTM); and
- Suspend enforcement of standards/metrics impacted by COVID-19, except actions that impact beneficiary access to care or the absence of which may pose potential beneficiary harm.

In the long-term, we encourage CMS to use its demonstration authority to develop an industry-wide standard that appropriately measures quality during this pandemic and provides plans with 3.5 or 3 Star Ratings with the opportunity to earn a QBP for contract years 2022 and 2023 (2021 and 2022 Star Ratings) of at least 3.5 percent. We encourage the agency to avoid using data affected by COVID-19 and other extreme and uncontrollable circumstances in the Star Ratings calculations. If CMS does not make broader changes to the Star Ratings program due to the pandemic, at a minimum, the agency should consider a broader view of the extreme and uncontrollable circumstances policy.

Recommendation Detail:

The Star Ratings will not accurately measure quality during this pandemic, and data will be incomplete at a minimum in 2021 and 2022. We appreciate CMS' efforts to maintain and improve care for beneficiaries during this public health emergency, and encourage the agency to make necessary changes to the Star Ratings to enable plans to shift focus and attention to addressing the quality of patient care during this pandemic. CMS should partner with plans to deploy trusted resources to help beneficiaries remain safely in their homes to help avoid the further spread of the virus.

Below are examples of activities that Anthem has implemented to prioritize our beneficiaries' health during this challenging time:

- Providing access to COVID-19 testing at no cost: Anthem is providing coverage of the coronavirus screening test at no out-of-pocket-cost by waiving copays, coinsurance and deductibles for the diagnostic test related to COVID-19.
- Encouraging broader use of telehealth: Our beneficiaries can see a doctor online, and receive virtual care, and flexible pharmacy benefits. For 90 days, Anthem's affiliated health plans will waive any beneficiary cost-share for telehealth visits, including visits for mental health, for our fully insured employer plans, Individual plans, Medicare plans and Medicaid plans, where permissible. In addition, we have deployed the Sydney Care COVID-19 symptom assessment tool to help determine a patient's risk for COVID-19, and whether they should visit their local health care provider for testing. To comply with the CDC guidelines and social distancing mandate to avoid large crowds, we have stopped in-person events that enabled on-site screenings/testing and beneficiary education.
- Relaxing early prescription refill limits: We are relaxing early prescription refill limits for beneficiaries who wish to receive a 30-day supply of most maintenance medications, where permissible. We are also encouraging beneficiaries who have a pharmacy plan that includes a 90-day benefit to talk to their doctor about whether changing from a 30-day supply to a 90-day supply of any prescription medicines they take on a regular basis is appropriate.
- Expanding access to 24/7 NurseLine: beneficiaries can use Anthem's 24/7 NurseLine if they suspect symptoms of COVID-19. Our nurses ask additional questions to beneficiaries with respiratory symptoms and coach members to use updated HealthWise Connect COVID-19 information and the CDC web site.
- Conducting outreach to beneficiaries: Anthem is conducting outreach call campaigns to provide beneficiaries with a touch point to answer questions, address any fears or concerns about access, and address social isolation.

The recommendations below assume the public health emergency has ended and the number of affected beneficiaries impacted has greatly decreased by January 1, 2021. For the 2021 and 2022 Star Ratings, we would recommend CMS immediately:

- Suspend chart pulls for Healthcare Effectiveness Data and Information Set (HEDIS) measurements: Impose an industry-wide cease and desist of HEDIS Medical Record Review (MRR) and follow-up to ask providers for charts and less time sensitive information. We are concerned unnecessary contact with providers can take time away from caring for patients, and many offices have closed to non-urgent patient visits. Furthermore, this change will enable plans to redeploy resources to serve our beneficiaries and collaborate with providers to support efforts to combat COVID-19.
- Enable plans to shift focus from inquiries to providers as a basis for measuring Stars: Given pandemic-related challenges we would appreciate guidance enabling plans to cease activities designed to improve Star Ratings including provider engagement activities related to preventative screenings, such as mammograms, which are considered non-emergency health services.
- Enable plans to cease outreach to beneficiaries for non-emergent care as a basis for measuring Stars: Provide guidance enabling plans to cease outreach that would be counterproductive to beneficiaries' health such as encouraging members to seek non-emergency health services

(e.g., participating in preventive screenings, making a primary care appointment), or asking beneficiaries to respond to the CAHPS or the HOS surveys at this time. To prevent the further spread of the virus, CMS should suspend any Star Ratings measures that require non-emergency care from a provider. Part C and D HEDIS measures will be particularly impacted, and CMS has already recommended postponing non-essential medical, surgical, and dental procedures during the COVID-19 response.

- Account for the pandemic in the standard operational processes that may be impacted such as CTMs: Given the impact of COVID-19 on beneficiary access as providers are deployed to focus on COVID-19 emergencies, and many providers are limiting or ceasing non-emergency visits to ease the spread of the virus, we are concerned about a potential increase in beneficiary complaints. We encourage the agency to account for the challenges of this public health emergency by holding plans harmless for CTMs outside of their control.
- Suspend enforcement of standards/metrics impacted by COVID-19: We urge the agency to waive all enforcement of standards/metrics that are impacted by the rapid proliferation of new COVID-19 guidance and administrative decisions (e.g., customer service metrics due to increased call volumes), except those that impact beneficiary access to care or the absence of which may pose potential beneficiary harm. Furthermore, we encourage the delay of all audits such as data validation, program, and financial audits to enable MAOs to focus on addressing beneficiaries' needs during the COVID-19 pandemic.
- Consider extending the telehealth flexibilities: We encourage the agency to allow telemedicine visits as valid encounters for documentation of diagnosis codes used for the calculation of risk scores. In addition, we expect that beneficiaries will have lingering concerns related to provider visits even after the pandemic, therefore, CMS should extend the telehealth flexibilities beyond the public health emergency.

During this public health emergency, the Star Ratings program should move away from the current approach of contract-level ratings, towards measuring best practices to provide quality care for beneficiaries across the MA program during the pandemic. If changes to the Star Rating program are not made, plans could conduct activities that are counterproductive to the health and welfare of beneficiaries and frontline health workers.

Due to the pandemic, reporting of quality measures will be incomplete for 2021 Star Ratings (HEDIS and CAHPS) and 2022 Star Ratings (all measures). The Star Ratings program is designed to measure health quality across the country. However, states, counties, and cities are putting in place different public health protocols to combat COVID-19, therefore, it will not be possible to fairly measure Star Ratings in 2021 or 2022.

We encourage CMS to develop an industry-wide standard that appropriately measures quality during this pandemic. We encourage the agency not to calculate Stars for rating years 2021 and 2022, as is, and reset the Star Ratings program beginning with measurement period January 2021 for 2023 Star Ratings. At a minimum, plans with a rating of 4 or more stars for the 2020 Star Ratings should continue to earn a QBP for Revenue Years 2022 and 2023. To improve program stability, all other plans with 3 and 3.5 stars in 2020 should be eligible earn up to a 3.5 percent QBP in 2022 and 2023. CMS should use its demonstration authority to make these changes.

Expand the Definition of Impacted Organizations

Recommendation Summary: We encourage the agency to avoid using data affected by COVID-19 and other extreme and uncontrollable circumstances in the Star Ratings calculations. If the agency does not make broader changes to the Star Ratings program due to the pandemic, at a minimum, the agency should consider a broader view of extreme and uncontrollable circumstances. Specifically, we request that CMS expand eligibility for the policy in the event of a state or local public health emergency, when the HHS Secretary declares a public health emergency, or in the event of a FEMA emergency or FMAG declaration for which public or individual assistance is available.
We are particularly concerned that unprecedented high-wind events, resulting in fires and evacuations across California in 2019, are not included in the list of events in the Advanced Notice that authorize the HHS Secretary to temporarily modify or waive Medicare requirements. We encourage CMS to include the fires and extreme weather conditions in California that led the Governor to declare a statewide emergency to the list of extreme and uncontrollable circumstances to achieve accurate performance measurements in the Star Ratings program.[22]

Outbreaks such as the COVID-19 pandemic may cause supply chain disruptions, prescription drug shortages, and prevent beneficiaries from obtaining necessary care, which represent extreme events over which plans have little to no control. To account for these incidents, we encourage CMS to expand and align the processes the agency plans to implement as the COVID-19 situation evolves. The agency should also consider permitting plans to make the case for such a determination by providing an impact assessment of the effect of the event on its beneficiaries and operations.

Recommendation Detail: Anthem appreciates CMS' acknowledgment of the impact of natural disasters and extreme and uncontrollable circumstances through the development of the Star Ratings policy, as well as efforts to work with plans, providers, and beneficiaries negatively impacted. We are committed to providing access to high-quality care and support services to beneficiaries living in areas impacted by disasters, and public health emergencies like COVID-19, and we are eager to work with CMS to ensure beneficiaries continue to receive necessary services and quality care despite uncontrollable circumstances. We recommend CMS expand the criteria required to trigger the Star Ratings policy, as implementation of the current policy has sparked confusion for both beneficiaries and MAOs experiencing extreme and uncontrollable circumstances.

When a federal or state emergency or disaster is declared, Anthem acts quickly to inform beneficiaries and providers of benefit changes. We work to ensure our beneficiaries receive timely access to needed healthcare services by removing barriers, making outreach calls, and expanding access to providers, medications, and replacement equipment and supplies. For example, in 2018 we leveraged our LiveHealth Online telehealth service and Employee Assistance Program to help residents in Alabama, Florida, Georgia, and North Carolina impacted by Hurricane Michael.[23] We have acted during hurricanes, fires, floods, and earthquakes to address our beneficiaries' needs – and we are currently acting quickly to care for COVID-19 patients; however, not all of these events are taken into consideration by CMS' extreme and uncontrollable circumstances policy.

[22] Office of Governor Gavin Newsom. "Governor Newsom Declares Statewide Emergency Due to Fires, Extreme Weather Conditions." October 27, 2019. https://www.gov.ca.gov/2019/10/27/governor-newsom-declares-statewide-emergency-due-to-fires-extreme-weather-conditions/.
[23] Anthem. "Anthem Activates Plan to Help Residents Impacted by Hurricane Michael". October 11, 2018. https://ir.antheminc.com/news-releases/news-release-details/anthem-activates-plan-help-residents-impacted-hurricane-michael?field_nir_news_date_value[min]=.

Currently, the policy limits Star Ratings adjustments to "emergency areas" for "emergency periods," where Stafford Act declarations of a major disaster are applicable. In addition, the Secretary must exercise authority to temporarily modify or waive certain Medicare provisions as a result of the disaster. Finally, beneficiaries must reside in FEMA-designated individual assistance areas at the relevant time. The policy fails to acknowledge State disaster declarations, FEMA emergency declarations, or FMAG declarations that provide funds to assist in combating wildfires. The policy also fails to acknowledge state and local public health emergencies, or a public health emergency declared by the HHS Secretary absent a section 1135 waiver. Furthermore, the policy is limited to FEMA-designated individual assistance areas, but does not include instances where FEMA designates public assistance and hazard mitigation assistance areas in order to provide aid in the wake of disasters that impact local communities.

Because the current policy fails to acknowledge the impact of all disaster types on beneficiaries and MAO operational and clinical systems, the Star Ratings do not reflect the full impact of extreme and uncontrollable circumstances. This has led to inconsistencies in the quality measurement data used to calculate Star Ratings, affecting the accuracy of the quality data beneficiaries rely on to make informed plan decisions.

In particular, California has been hard hit over the past three years by large fires, other natural disasters, and now COVID-19. The fires prompted the HHS Secretary to issue a public health emergency effective February 6, 2019, as a result of the continued consequences of the wildfires on the State of California.[24] In 2019 alone, FEMA issued ten FMAG declarations for California to combat active wildfires.[25] [26]

In just one example, in October 2019, the Saddle Ridge Fire burned in Los Angeles County for 21 days, killing one person, injuring eight, destroying 19 structures and damaging 88 others, burning 9,000 acres of land, threatening 1,069 homes, and requiring the mandatory evacuation of roughly 10,000 people in and around the communities of Sylmar and Granada Hills in Los Angeles County. On October 11, Governor Newsom declared a State of Emergency in Los Angeles due to the Saddle Ridge Fire.[27] On October 11, FEMA issued an FMAG declaration for the Saddle Ridge Fire, releasing public and hazard mitigation assistance. Despite the devastating disaster, the fact that over 40,000 Anthem beneficiaries reside in Los Angeles County, and 36 percent of the members in our California HMO contract H0544 were impacted, the event did not qualify for the Star Ratings adjustment in the extreme and uncontrollable circumstances policy because the fire did not receive a major disaster declaration.

CMS has acknowledged that plans complete many preventive screenings at the end of the calendar year, so disasters towards the end of the year may have an inordinate impact on Star Ratings. These events had the potential to impact beneficiaries' ability to receive preventive screenings, and necessary care, yet no California counties are eligible for Star Ratings relief in 2021.

Furthermore, the policy as currently written is so narrowly tailored that this year only the earthquakes in Puerto Rico qualified. Despite persistent disasters, over time the number of contracts that meet the

[24] HHS, Public Health Emergency. "Renewal of Determination that a Public Health Emergency Exists." February 6, 2019. https://www.phe.gov/emergency/news/healthactions/phe/Pages/ca-wildfires-renew-30Jan2019.aspx.
[25] FEMA. "Disasters." www.fema.gov. Accessed February 19, 2020. https://www.fema.gov/disasters.
[26] FEMA. "The Disaster Declaration Process." Accessed February 19, 2020. https://www.fema.gov/disaster-declaration-process.
[27] Office of Governor Gavin Newsom. "Governor Newsom Declares State of Emergency in Los Angeles and Riverside Counties Due to Fires." October 11, 2019. https://www.gov.ca.gov/2019/10/11/governor-newsom-declares-state-of-emergency-in-los-angeles-and-riverside-counties-due-to-fires/.

eligibility criteria has steadily declined. In 2019, 77 contracts met the 25 percent threshold, and 57 met the 60 percent threshold. Therefore, of the 376 MA-PD contracts with a Star Rating in 2019, 20 percent of contracts met the 25 percent threshold, and 15 percent of contracts met the 60 percent threshold. However, in 2020, only 23 contracts met the 25 percent threshold (including one PDP), and 8 met the 60 percent threshold. Of the 401 MA-PD contracts with a Star Rating in 2020, only 5 percent of contracts met the 25 percent threshold and 2 percent of contracts met the 60 percent threshold.

The extreme and uncontrollable circumstances policy should take into account all local, state and federal public health emergency and disaster declarations to provide a consistent and accurate view of plan quality in impacted areas. CMS should consider the impact of California wildfires that are becoming an almost annual disruption to Medicare beneficiaries and Star Ratings data, and allow the FMAG declaration when public assistance is available to qualify for relief. Expanding the current policy will ensure that beneficiaries are not unfairly penalized by fewer plan benefit options when quality thresholds are impacted by extreme and uncontrollable circumstances.

Align the Definition of Impacted Organizations

Recommendation Summary: We encourage CMS to align its policies related to disasters, catastrophic events, and public health emergencies across the MA program. Harmonizing the thresholds used to require MAOs to provide benefit flexibilities, Special Enrollment Periods (SEPs), and pharmacy access will provide expanded relief for beneficiaries and ensure accurate quality measurement in the event of extreme and uncontrollable circumstances.

Recommendation Detail: Aligning Star Ratings disaster relief with the thresholds used to determine eligibility for benefit accommodations for plan beneficiaries will provide a more rational and seamless application of CMS' disaster relief provisions. In the Advanced Notice, CMS limits the Star Ratings waivers to FEMA major disaster declarations, and enumerates additional criteria that limits the application of accommodations for Star Ratings. We have identified at least four conflicting CMS policies that provide guidance to MAOs with respect to emergency access to provider networks and medications in the event of an emergency.

First, Section 150 in chapter four of the Medicare Managed Care Manual (MMCM) outlines certain MA benefit limitations that may be waived in the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, or a declaration of emergency or disaster by a Governor.[28] Specifically, MAOs must allow Part A and Part B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities, waive requirements for gatekeeper referrals, and reduce plan-approved out-of-network cost-sharing to in-network cost-sharing amounts.

Second, Section 30.4.4 of chapter two in the MMCM provides the HHS Secretary with authority to establish SEPs when beneficiaries are affected by a FEMA-declared weather related emergency or major disaster.[29] A beneficiary must reside in an area for which FEMA has declared an emergency or a major disaster and has designated affected counties as eligible to apply for individual or public level assistance.

[28] CMS. "Medicare Managed Care Manual - Chapter 4 - Benefits and Beneficiary Protections." April 22, 2016. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.
[29] CMS. "Medicare Managed Care Manual - Chapter 2 - Medicare Advantage Enrollment and Disenrollment." July 31, 2018. https://www.cms.gov/Medicare/Eligibility-and Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2019_MA_Enrollment_and_Disenrollment_Guidance.pdf.

In addition, the SEP is available to individuals who don't live in the affected areas, but rely on help making healthcare decisions from friends or family members who live in affected areas.

Third, in Chapter 5 of the Prescription Drug Benefit Manual (PDBM) Manual, CMS requires that if a Presidential major disaster or emergency declaration is issued or the Secretary declares a public health emergency, plan sponsors must lift "refill-too-soon" edits.[30] CMS also requires Part D sponsors to allow affected beneficiaries to obtain the maximum extended day supply, if available at the time of refill.

A fourth guidance document outlines expectations of Part C and Part D plan sponsors in the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary—but absent an 1135 waiver by the Secretary. [31] The HPMS memo from 2009 combines and clarifies requirements in MA and Part D. We encourage CMS to release more comprehensive and expansive updated guidance.

We are concerned the misalignment of disaster thresholds across the MA program undermines appropriate relief to beneficiaries and plan sponsors. CMS should harmonize the thresholds, using more expansive qualifications, to ensure appropriate flexibilities in the event of extreme and uncontrollable circumstances. An emergency or disaster declaration at the local, state, or federal level should allow impacted beneficiaries to access additional benefits and prompt CMS to provide flexibility in the quality assessment of plans operating in impacted areas in order to provide appropriate and consistent relief across the program.

Aligning the type of declarations required to permit benefit limitation waivers and SEPs, as well as trigger the extreme and uncontrollable circumstances policy in Star Ratings, will greatly benefit beneficiaries recovering from the effects of emergencies, and help smooth operational challenges as plans respond to such events. We encourage CMS to further refine its extreme and uncontrollable circumstances policies across the MA program.

Avoid Penalizing Beneficiaries in the Event of a Disaster

Recommendation Summary: Anthem requests that CMS re-evaluate the application of the extreme and uncontrollable circumstances policy to contracts impacted across multiple years, and to improvement measures, to hold beneficiaries harmless. Currently, when a contract is impacted across three years, CMS will only provide relief over one year, rather than two years. Additionally, for improvement measures if the plans' Star Ratings are the same, CMS applies the more recent rating, even if the underlying measure scores are not the same.

The current policy fails to hold beneficiaries harmless by limiting the availability of quality bonus payments that plans use to lower cost-sharing and increase benefits for beneficiaries. Moving forward, CMS should account for every year the contract experiences an extreme and uncontrollable circumstance by providing relief over multiple years. In addition, if a contract gets the same Star Rating

[30] CMS. "Medicare Prescription Drug Benefit Manual – Chapter 5." September 20, 2011. https://www.cms.gov/Medicare/Prescription-Drug Coverage/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5_093011.pdf.
[31] CMS, Center for Drug and Health Plan Choice. "Pharmacy and Provider Access during a Federal Disaster or Other Public Health Emergency Declaration," July 20, 2009.

in both years, CMS should take the higher of the two years' measure scores in order to ensure that plans and beneficiaries are truly held harmless in the event of a disaster.

Recommendation Detail: CMS' Disaster Adjustment policy is designed to take into account the effects of natural disasters, while holding beneficiaries and contracts harmless when uncontrollable conditions affect plan performance. CMS proposes if a contract experienced extreme and uncontrollable circumstances in 2022, the 2021 Star Ratings may be used, however, the 2021 Star Ratings would not be used in determining the 2023 Star Ratings if the contract was once again impacted by extreme and uncontrollable circumstances. Therefore, CMS does not take into account double impacted contracts.

In some areas of the country our contracts have experienced three straight years of natural disasters. We are concerned about CMS' proposal not to grandfather in extreme and uncontrollable circumstance relief across multiple years. We encourage CMS to grant relief beyond two years of disasters and recognize that only data that is not impacted by such circumstances should be used to calculate accurate Star Ratings measures.

Furthermore, to calculate improvement measures in light of a disaster, CMS compares the current, and previous years of a contract's Star Ratings and uses the higher Star Rating (or more recent if the two are equal) and corresponding measure scores. We are concerned the current methodology does not achieve the goal of holding beneficiaries and plans harmless the agency does not take the higher measure scores in the year in which an extreme or uncontrollable circumstance occurred.

Anthem beneficiaries in Florida experienced such an unintended consequence in the application of the disaster adjustment policy. Simply Healthcare Plans, Inc. (Simply) serves Medicare beneficiaries in South and Central Florida. Due to Hurricane Irma in September 2017, the policy was applied. However, CMS did not apply the higher of the two-year measure scores to calculate the health plan improvement measure (Measure C31). Simply's Star Ratings for three measures (measures C02: Colorectal Cancer Screening; C24: Getting Appointments and Care Quickly; C28: Care Coordination) were consistent across 2017 and 2018; but, the measure score was lower in 2018. Despite the disaster adjustment policy, CMS did not use the higher of the two measure scores because the Star Ratings were the same. The lower measure scores were used in the improvement calculation, negatively impacting the plan's overall Star Rating. Perversely, the contract would have been better off had it not made any attempts to perform well on the measure in the wake of the natural disaster, which would have negatively impacted beneficiaries.

The current policy inadvertently penalizes beneficiaries in plans like those described above. Moving forward, if a contract is impacted over multiple years, CMS should look back to the most recent unaffected year's data. In addition if a contract gets the same Star Rating in both years, CMS should take the higher of the two years' measure scores in order to ensure that plans are truly held harmless in the event of a disaster. At minimum, CMS should exclude the measure from the quality improvement calculation.

Lower Threshold of Impacted Beneficiaries

Recommendation Summary: Anthem encourages CMS to lower the 25 percent threshold of membership affected by extreme and uncontrollable circumstances to 20 percent.

Recommendation Detail: We ask CMS to reconsider the 25 percent threshold proposal that triggers the extreme and uncontrollable circumstances policy in the Star Ratings. While we appreciate CMS' attention to extreme and uncontrollable circumstances that may impact MA and Part D contract performance on Star Ratings measures and/or measure level data, we are concerned requiring contracts to have 25 percent of enrollees residing in a FEMA-designated individual assistance area at the time of the extreme and uncontrollable circumstance is setting the threshold too high. Instead, we encourage CMS to lower the threshold to 20 percent of enrollees impacted by uncontrollable circumstances, because at this lower percentage Star Ratings are materially affected.

There is precedence for a 20 percent threshold. For example, CMS asserted that for the purposes of determining quality performance scoring for performance year 2017, if 20 percent or more of an Accountable Care Organization's (ACO's) assigned beneficiaries reside in an area impacted by the disaster, the ACO's minimum quality score will be set to equal the mean Shared Savings Program ACO quality score for all ACOs for performance year 2017.[32] We encourage CMS to revisit the 25 percent threshold to harmonize extreme and uncontrollable circumstance policies across Medicare programs.

Assess Natural Disasters in Aggregate

Recommendation Summary: In California in 2019, wildfires, severe storms, and earthquakes impacted thousands of Anthem beneficiaries, and in two contracts, 25 percent and 57 percent of beneficiaries were impacted when the disasters are analyzed in aggregate. However, the current policy requires that at least 25 percent of enrollees must reside in a FEMA-designated individual assistance area at the time of the incident. We encourage CMS to clarify its methodology to look at natural disasters in aggregate, rather than per incident.

Recommendation Detail: We encourage CMS to clarify and revise its methodology to look at natural disasters in aggregate. Currently, it is unclear how the proposed policy impacts a contract with different beneficiaries affected by different disasters at different time periods. For example, a group retiree contract with members across the country may not qualify for relief because beneficiaries experience different disasters in a given year that do not individually meet the 25 percent threshold.

As shown in the data enclosed in our comments, in 2019, different beneficiaries were negatively impacted by wildfires, severe storms, and earthquakes across California. In this situation, we may not meet the required threshold for any one disaster, but we would meet the threshold when these disasters are considered in their totality. Anthem requests clarification from CMS on how to calculate the relative percentages of beneficiaries impacted by the extreme and uncontrollable circumstances policy. We encourage CMS to holistically assess the impact of natural disasters in determining application of the policy.

Permitting a Second, "Preferred," Specialty Tier in Part D (§§ 423.104, 423.560, and 423.578)

Recommendation Summary: Anthem appreciates CMS' proposal to allow for a second, preferred specialty tier. However, we are concerned the proposal in its current form will lead to higher plan costs, which in turn will increase premiums for beneficiaries. To minimize premium increases, we recommend

[32] Federal Register. "Medicare Program; Medicare Shared Savings Program: Extreme and Uncontrollable Circumstances Policies for Performance Year 2017." December 2017. https://www.govinfo.gov/content/pkg/FR-2017-12-26/pdf/2017-27920.pdf.

that CMS increase the maximum cost-sharing on the preferred specialty tier to between 25 and 33 percent coinsurance and increase the maximum cost-sharing on the non-preferred specialty tier to between 30 and 40 percent coinsurance (depending on a plan's deductible).

Recommendation Detail: CMS proposes to allow Part D sponsors to establish up to two specialty tiers and design an exceptions process that exempts Part D drugs on these tiers from tiering exceptions to non-specialty tiers. To implement this proposal, CMS would require that if a Part D sponsor has a plan with two specialty tiers, one must be a preferred tier that offers lower cost-sharing than the higher cost-sharing tier, which is subject to the proposed maximum allowable specialty-tier cost-sharing. CMS also proposes to permit Part D sponsors to determine which drugs are placed on each tier.

We appreciate CMS' effort to establish a second, preferred specialty tier. As CMS notes, this feature could improve plans' ability to negotiate with manufacturers to lower drug prices for beneficiaries. However, because cost-sharing on the non-preferred tier would not be permitted to exceed 33 percent, we are concerned that, as proposed, the additional specialty tier flexibility would put upward pressure on premiums, particularly if Part D sponsors cannot reduce net plan costs through higher rebates.

Given the potential for increased plan liability, we recommend CMS permit Part D sponsors to set the maximum permissible cost-sharing to between 25 to 33 percent coinsurance on the preferred specialty tier and between 30 and 40 percent coinsurance on the non-preferred specialty tier depending on the plan's deductible.

Related to this proposal, we also ask CMS to clarify that the second specialty tier would be in addition to the total allowed number of drug tiers, rather than in place of an existing tier.

Tier Composition

We support CMS' proposal to allow Part D sponsors to place both brand-name drugs as well as generic drugs and biosimilars on the preferred tier. If the preferred specialty tier were limited only to certain types of drugs, the ability to negotiate with manufacturers and generate meaningful reductions in drug costs for beneficiaries would be diminished.

Tiering Exceptions

We also support CMS' proposal to exempt drugs on the specialty tiers from tiering exceptions to non-specialty tiers. We ask that plans only be required to permit tiering exceptions for drugs on the non-preferred specialty tier to the preferred specialty tier if CMS increases the maximum cost-sharing amounts on the preferred specialty tier as per our recommendation above. We believe this proposal strikes the appropriate balance of affordability and access.

Beneficiary Real Time Benefit Tool (RTBT) (§ 423.128)

Recommendation Summary: Anthem supports providing beneficiaries with tools to understand and compare costs for prescription drugs. However, we recommend CMS delay the implementation date for the beneficiary RTBT requirement until 2024 to ensure adequate time to build and test these capabilities.

Recommendation Detail: CMS is proposing to require Part D sponsors to implement a beneficiary RTBT that would allow beneficiaries to view accurate, timely, and clinically appropriate patient-specific real-time formulary and benefit information, effective January 1, 2022.

Anthem supports the development of RTBTs and believes the information provided to clinicians and beneficiaries through these tools can enhance shared decision-making and ultimately improve adherence and clinical outcomes. Given that prescribers now have access to RTBTs to provide beneficiaries with complete, accurate, timely, and clinically appropriate patient-specific real-time formulary and benefit information at the point of prescribing, we ask that the agency provide more time for development of a beneficiary-specific RTBT. The implementation of these tools to CMS' specifications will take time, resources, design, development, and testing. It's important to be thoughtful as we overlay our existing capabilities with uniform industry-wide standards.

We are concerned that premature requirements for functional capabilities and implementation will result in the deployment of tools that are not as useful to beneficiaries as they could otherwise be. Furthermore, because our planning, designing, and implementation of technology-based solutions is an 18-24-month process, should CMS move forward with the proposed effective date, we recommend January 1, 2022, be a date for voluntary adoption of RTBTs, with their required use by January 1, 2024. This extension would also make it more likely that uniform standards are sufficiently developed to allow for the effective implementation of beneficiary RTBTs.

Finally, we support the proposed flexibility to exclude the negotiated price of a drug from beneficiary RTBTs. Presenting this information to beneficiaries in addition to their out-of-pocket costs, may become too confusing and burdensome and does not provide meaningful information to most beneficiaries.

Establishing Pharmacy Performance Measure Reporting Requirements (§ 423.514)

Recommendation Summary: Anthem is focused on ensuring that we provide our beneficiaries access to high-quality pharmacy networks that incentivize lower costs and improve health outcomes. We support and are involved in efforts to develop consensus-based pharmacy performance measures through the PQA. We also support CMS' proposal to collect pharmacy performance metrics used by Part D plan sponsors to evaluate pharmacy performance once industry has had an opportunity to develop, test, and achieve consensus on the measures.

Recommendation Detail: CMS proposes to amend its reporting requirements to establish that Part D sponsors disclose to CMS the pharmacy performance measures they use to evaluate pharmacy performance as established in their network pharmacy agreements.

Pharmacies play an important role in the health of beneficiaries—especially for those with chronic conditions. For example, pharmacy efforts to ensure adherence through education, refill reminders, and out-of-pocket cost reductions using generics can all reduce disease burden and greatly improve health outcomes. We strive to provide high-quality pharmacy networks to our members, and create value-based partnerships with pharmacies that align with the goals of the Star Ratings program. Direct and Indirect Remuneration (DIR), including pharmacy price concessions, are important tools for maximizing value and keeping beneficiaries' Part D premiums low. Through our PBM arrangements, we create high-

performing pharmacy networks that are consistently monitored and include incentives that align with better beneficiary care.[33]

We support disclosing to CMS our pharmacy performance measures used to evaluate pharmacy performance. We appreciate the role CMS plays in creating alignment between the Part D sponsors, pharmacy retail networks, and medical providers to support better healthcare outcomes and cost reduction. Furthermore, we understand the need for greater consensus among Part D plan sponsors regarding measurement as consistent public reporting supports transparency and fairness among all pharmacies and PBMs.

We also support CMS' approach to have the industry first develop, test, and achieve consensus on the metrics via a measure developer. To that end, Anthem is actively engaged in PQA's transparent and consensus-driven process to streamline and enhance quality measurements for pharmacies. Through the PQA process, we are pursuing several areas for measure standardization: adherence measures for diabetes, high cholesterol, hypertension/heart disease, statin use in diabetes, and comprehensive medication review completion rate. Additional measures being explored include formulary compliance (percentage of generic usage) and a measure of a beneficiary's experience with obtaining their prescriptions at the retail pharmacy (customer service and member satisfaction).

We are encouraged that CMS proposes to continue to rely on the ongoing process being undertaken by PQA and others, prior to issuing any additional data collection guidance. This will help to ensure a robust collection of industry accepted, tested, and validated measures.

Furthermore, should CMS develop Part D Star Ratings metrics related to these measures, we recommend the agency follow its traditional approach and report the results on the display page before implementation.

In addition, while not proposed in this rule, we would like CMS to consider for future plan years, the ability for Part D plan sponsors to develop preferred specialty pharmacy networks. The innovation of preferred retail pharmacy networks has significantly reduced Part D program costs, including government costs and beneficiary premiums. By allowing Part D plans to establish preferred specialty pharmacy networks, Part D sponsors will be in a position to better manage the proliferation of specialty drug spending for beneficiaries and taxpayers. The use of specialty pharmacy networks is an important tool for keeping premiums low. The growing cost of prescription drugs in the U.S. is one of the most important and challenging health policy issues we face today, and we are committed to working with CMS to help ensure Medicare beneficiaries have access to the best possible health care in a way that maximizes value and affordability.

Medical Loss Ratio (MLR) (§§ 422.2420, 422.2440, and 423.2440)

Recommendation Summary: Anthem supports CMS' proposed change to the definition of incurred claims to allow for accurate accounting of SSBCI benefits. We encourage CMS to consider extending this

[33] In developing our preferred network, Anthem targets a broad array of pharmacies for participation including national discount chains, national drug chains, national grocery chains, regional and rural pharmacy chains, and over 5,000 independent pharmacies.

approach to allowing COVID-19 investments to be considered an incurred cost, thereby allowing such investments to be applied to the numerator of the MLR.

Recommendation Detail: We applaud CMS' proposed change as it builds on the guidance allowing plans to cover non-primarily health related Supplemental Benefits (e.g., food/produce, transportation for non-medical needs, general support for living) for chronically ill MA beneficiaries.

CMS proposes changes to the "incurred claims" definition in the MLR calculation. Specifically, to account for the expanded benefit flexibility MA plans deliver under SSBCI, which may include non-provider payments, the agency proposes to remove the specification that incurred claims are payments to providers for covered services.
The proposed changes to the definition of "incurred claims" will make it less burdensome for MAOs to include these expanded supplemental benefits in the MLR numerator and incentivize increased investments in beneficiaries and their communities through the private sector.

Given the growing body of medical evidence demonstrating 1) that food insecurity among Medicare beneficiaries significantly increases healthcare expenditures in all areas of the country, 2) the positive impact of interventions such as medically tailored meals in reducing healthcare costs in Medicare and dually eligible beneficiaries, and 3) the impact of these and similar interventions on reductions in hospital and skilled nursing admissions across multiple payer types, the proposal supports work addressing the social drivers of health to improve the lives of MA beneficiaries.[34] [35]

Furthermore, many of our SSBCI benefits are not delivered by providers. Therefore, we appreciate CMS' acknowledgement that SSBCI should be included in the numerator as expenses plans incur to deliver important new flexible supplemental benefits that help address social drivers of health.

Given the unprecedented threat of COVID-19 to our healthcare system and beneficiaries, we recommend that CMS consider extending this approach to allow COVID-19 investments in supplemental benefits to keep people in their homes to be considered an incurred cost, thereby allowing such investments to be applied to the numerator of the MLR. It's critical that all resources are brought to bear to prevent vulnerable MA beneficiaries from contracting the virus, while continuing to address food insecurity and social isolation, particularly during this public health emergency.

This proposed rule change would establish the leadership of this Administration as the first to incorporate social drivers of health into the MLR framework. The use of the SSBCI has the potential to greatly improve the health of MA beneficiaries, and we encourage CMS to enable social investments more broadly to be included in the MLR numerator. This proposed change will start to eliminate an administrative barrier to expanding the use of benefits to invest in wellness, improve health outcomes, and reduce the long-term costs of medical care.

[34] Seth A. Berkowitz et al. "Preventing Chronic Disease Section Navigation State-Level and County-Level Estimates of Health Care Costs Associated with Food Insecurity." July 11, 2019. https://www.cdc.gov/pcd/issues/2019/18_0549.htm.
[35] Seth A. Berkowitz et al. "Meal Delivery Programs Reduce the Use of Costly Health Care in Dually Eligible Medicare and Medicaid Beneficiaries." April 2018. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0999.

Dismissal and Withdrawal of Medicare Part C Organization Determination and Reconsideration and Part D Coverage Determination and Redetermination Requests (§§ 422.568, 422.570, 422.582, 422.584, 422.590, 422.592, 422.631, 422.633, 423.568, 423.570, 423.582, 423.584, and 423.600)

Recommendation Summary: We are concerned the proposed definitions do not provide the intended and necessary clarity. In particular, these definitions address situations where the requests for determination/redetermination were never valid requests. CMS should consider a new, separate classification that would not imply the request was initially valid, and also provide more clarity around the difference between dismissals and withdrawals.

Recommendation Detail: CMS is proposing to clarify the circumstances and processes for withdrawing or dismissing Part C determination and reconsideration requests and Part D coverage determination and redetermination requests. The agency is also proposing regulations to clarify processes and circumstances for withdrawing or dismissing Part C and Part D Independent Review Entity (IRE) reconsiderations.

Specifically, CMS is proposing to permit a plan to dismiss requests when 1) the individual or entity making the request is not permitted to make the request; 2) the plan determines that the individual or entity making the request failed to make a valid request; 3) the beneficiary dies while the request is pending and the beneficiary's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the request; or 4) the individual or entity who requested the review submits a timely written request for withdrawal of their request with the plan. CMS is also proposing an avenue to appeal a plan dismissal decision through an IRE.

Anthem does not believe the proposed definitions provide clarity around these issues. We are concerned requests that were invalid to begin with cannot be dismissed or withdrawn. In such instances CMS should not continue with the plan allowances to dismiss a case that should not have been started in the first place.

CMS is proposing to permit a plan to dismiss a request for the initial plan level coverage determination when the individual or entity who requested the review submits a timely written request for withdrawal. Currently, plans use the withdrawal process, which is a different decision type than a dismissal. We recommend CMS follow the withdrawal process in this scenario, not the dismissal process. In addition, when a beneficiary dies during the request process, we recommend CMS follow the withdraw process rather than the dismissal process.

Furthermore, the agency also seeks comment on whether the proposed rules would create inconsistencies with any state-specific Medicaid procedures pertaining to dismissals or withdrawals. Medicare determination and coverage processes may be different than Medicaid, therefore, if medical care or services are not covered by Medicare, but are covered by Medicaid, withdrawing the appeal is an effective way to minimize the administrative burden of appeals in Medicare.

We encourage CMS to provide more clarity around the circumstances under which a dismissal process is followed versus a withdrawal process and the different expectations associated with these two processes.

E. Codifying Existing Part C and D Program Policy

Maximum Out-of-Pocket (MOOP) Limits for Medicare Parts A and B Services (§§ 422.100 and 422.101)

Recommendation Summary: While we appreciate CMS' consideration of the inclusion of an intermediate tier for the MOOP limit and a multi-year transition that incorporates ESRD costs to provide benefit design flexibilities, we are concerned the changes to the MOOP could be detrimental to non-ESRD beneficiaries. Inadequate payment for ESRD beneficiaries puts supplemental benefits, reduced cost-sharing, and the out-of-pocket cap protections for MA beneficiaries at risk. CMS should ensure adequate payment for ESRD beneficiaries by adjusting the benchmarks to avoid major changes for beneficiaries satisfied with their MA benefits.

Recommendation Detail: Beginning with coverage for the 2022 contract year, CMS proposes to 1) establish explicit authority for up to three MOOP limits, including the current mandatory and voluntary MOOP limits and a third, intermediate MOOP limit; 2) codify the methodology for setting MOOP limits; and 3) adjust the methodology to take into account more ESRD beneficiaries entering MA.

While the introduction of an intermediate MOOP limit to take into account a larger number of ESRD beneficiaries joining MA will make the MOOP more accurate, the policy will also increase costs for all MA beneficiaries. Instead, we encourage CMS to adjust benchmarks to account for the MOOP limit required in MA. Payment adequacy for patients with ESRD is increasingly important to enable plan sponsors to develop specialized plans that are better tailored to beneficiaries' chronic conditions.

We appreciate CMS' acknowledgement that current ESRD reimbursement is not sufficient to prevent premium increases to accommodate the higher costs of ESRD beneficiaries in MA.[36] However, we are concerned that CMS' proposal to enable MA plans to increase the MOOP will negatively impact all MA beneficiaries, while not fully addressing the payment shortfall for ESRD beneficiaries. In proposing to raise the MOOP for all MA beneficiaries, CMS is passing higher costs on to all MA consumers and setting up a situation in which beneficiaries without ESRD will subsidize those with ESRD.

Further, we are concerned the proposal could drive adverse selection. MAOs that endeavor to keep costs low for beneficiaries with a lower MOOP would disproportionately attract ESRD beneficiaries, compared to MAOs that utilize a higher MOOP. CMS is also proposing to increase the allowable increase in Total Beneficiary Cost (TBC), which would further increase costs for beneficiaries. Rather than increasing the MOOP and TBC, CMS should focus on preventing beneficiary cost increases by updating the ESRD benchmarks to directly address the payment shortfall for ESRD beneficiaries.

Plan Crosswalks for Medicare Advantage (MA) Plans and Cost Plans (§§ 417.496 and 422.530)

Recommendation Summary: We request clarity around Annual Notice of Change (ANOC) requirements when a plan crosswalks beneficiaries into two different plans.

Recommendation Detail: CMS proposes to codify crosswalk and crosswalk exception processes and conditions, including specific rules for SNPs. We request clarification as to whether two different ANOCs would be required in situations in which a plan crosswalks beneficiaries into two different plans.

[36] CMS, Medicare Drug & Health Plan Contract Administration Group, "Contract Year 2021 Part C Benefits Review and Evaluation," February 6, 2020.

Medicare Advantage (MA) and Cost Plan Network Adequacy (§§ 417.416 and 422.116)

Recommendation Summary: Anthem supports the proposed flexibilities to the MA network adequacy standards. We believe CMS' approach reflects the challenges with establishing a network in some geographies and facilitates access to telehealth innovations to close care gaps.

We recommend CMS remove outpatient dialysis from the list of facility types for which MA plans must meet time and distance standards, and allow plans to attest to providing medically necessary dialysis services in its contract application. These flexibilities will encourage competition and drive patient-centered innovation in dialysis treatment.

Particularly given the challenges associated with the COVID-19 outbreak, we appreciate that CMS has proposed flexibilities when a plan contracts with telehealth providers. We request further clarification from the agency on how MAOs can expand coverage of telehealth services beyond those approved by CMS.[37]

Recommendation Detail: Currently, CMS requires that MAOs contract with a sufficient number of specified providers/facilities to ensure that beneficiaries have adequate access to care near where they live. CMS proposes to codify most of its existing network adequacy standards, with some modifications to further account for access needs in all areas, including rural counties. These changes will also take into account the impact of telehealth providers in contracted networks.

- ESRD: We support the Administration's focus on increasing the use of home dialysis. Our ESRD SNPs have demonstrated success in providing beneficiary education around home dialysis, support services, and home care. To advance the Administration's goal of having 80 percent of new ESRD patients in 2025 either receiving dialysis at home or receiving a transplant, we encourage CMS to revise network adequacy requirements if a plan is able to show a percentage of patients utilizing home dialysis.

  CMS should also remove outpatient dialysis from the list of facility types for which MA plans need to meet time and distance standards, and allow plans to attest to providing medically necessary dialysis services in its contract application, instead of requiring each MA plan to meet time and distance standards for providers of these services. These flexibilities could help lower out-of-pocket costs for ESRD beneficiaries, and expand access to supplemental benefits and other services not found in traditional Medicare.

  We also encourage the agency to explore ways to provide dialysis in additional settings by broadening Medicare conditions of coverage for dialysis facilities. Expanding home dialysis is particularly important given the COVID-19 risks for ESRD beneficiaries. We would like to collaborate with CMS to encourage dialysis services in multiple venues by updating the Medicare conditions of coverage for dialysis facilities to include home training facilities and mobile dialysis facilities. We stand ready to partner with the Administration to achieve the 2025 goals to improve the lives of individuals with ESRD.

[37] CMS. "Information Related to Coronavirus Disease 2019 - COVID-19." March 10, 2020. https://www.cms.gov/files/document/hpms-memo-covid-information-plans.pdf.

- Telehealth: We encourage CMS to finalize its proposed 10-percentage point credit when a plan contracts with applicable telehealth providers. We believe that telehealth services can be an efficient and effective means to deliver care. Providing this credit both encourages further adoption of telehealth services for MA beneficiaries, and shows that telehealth services can be a high-quality alternative to traveling to a provider office or facility.

  We also encourage CMS to continue efforts to expand access to telehealth by providing further guidance on the ways MAOs may be approved to expand benefit packages to accommodate beneficiaries impacted by the COVID-19 outbreak, as the pandemic may provide valuable insights into flexibilities that should be made permanent.

  Furthermore, we recommend allowing telehealth encounters to be utilized for risk adjustment in 2021 and 2022 to improve risk score accuracy. Given the increasing use of telehealth to care for beneficiaries during this public health emergency, it will be important to incorporate diagnoses from telehealth encounters to maintain the stability of the MA program.

- Rural Areas: We also support CMS' proposed flexibility to implement an 85 percent time and distance standard for rural, micro, and Extreme Access Considerations counties (CEAC). Implementing this standard will increase the ability of MA plans to meet network adequacy standards, and thus increase choice and competition in rural areas. As CMS considers this change, we would also ask CMS to evaluate an 80 percent threshold, which we believe would further improve beneficiary plan choice, without creating impediments to access.

- Provider Consolidation: We echo statements CMS has received from stakeholders regarding strategies used by some providers to leverage network adequacy requirements in order to negotiate rates well above FFS. This issue may arise when all, or nearly all available providers of a certain specialty consolidate into a single practice, leading to potential negotiating challenges for MA plans working to adhere to network adequacy standards. We encourage CMS to create an exceptions process in the event a documented anticompetitive situation arises, impeding a plan's ability to achieve network adequacy.

- Certificate of Need: In addition, we support CMS' proposal that MAOs may receive a 10-percentage point credit for beneficiaries residing within published time and distance standards when provider and facility types in states are limited due to Certificate of Need laws, or other state imposed restrictions. Anticompetitive behavior increases overall health care costs for beneficiaries and taxpayers. We encourage the agency to finalize the update to network adequacy requirements as proposed.

Lastly, the data CMS uses to populate its provider availability information is not always current, shifting the burden to plans to refute inaccuracies. To this end, we urge CMS to develop a more accurate data source for provider information. We are supportive of CMS' concept to pilot the use of the National Plan and Provider Enumeration System as a "source of truth" that plans can use to validate provider directory data. In the meantime, acknowledging these errors, we ask CMS to more readily take plan data into consideration and facilitate a more streamlined exceptions process.

Past Performance (§§ 422.502 and 423.503)

Recommendation Summary: Anthem appreciates CMS' efforts to clarify and simplify the past performance methodology and the accommodation for intermediate sanctions related to D-SNPs, however, we are concerned that the proposal would be overly restrictive in its application. We encourage the agency to consider the factors in combination, as well as the size of the identified contract.

Additionally, given the negative impact of COVID-19 on Star Ratings, we recommend that CMS does not consider low Star Ratings as a determining factor to deny new contract and service area expansions. At a minimum, we encourage the agency to consider two to three years of Star Ratings performance to allow for improvement efforts to be measured and reported.

Furthermore, we recommend CMS exclude plans which have been, or will be non-renewed prior to the following contract year from the past performance review.

Lastly, given the narrow timeframe CMS proposes for review, we encourage the agency to provide plans with a remediation opportunity and an appeals process should the plan quickly address identified issues.

Recommendation Detail: CMS proposes to adopt an updated past performance methodology that uses a three pronged test as the basis for denying an MA or Part D application: 1) the imposition of Civil Money Penalties (CMPs) or intermediate sanctions, 2) failure to achieve at least a three-star Part C or Part D summary rating in the set of Star Ratings CMS issued during the 12-month review period, and 3) failure to maintain a fiscally sound operation.

Anthem appreciates the need to restrict the ability of poor performing plans to expand, particularly for plans with a history of poor performance. However, we do not believe the proposed methodology sufficiently takes into account the nature and context of performance issues over a sufficient period of time, and thus would inadvertently limit new high-quality plan offerings.

The agency previously used eleven different criteria in the past performance methodology. While the proposal does simplify the past performance evaluation, we believe CMS needs to add more nuance within the proposed criteria, potentially through the addition of a point system. For example, not all CMPs are equal in terms of severity, and a lower Star Rating on a contract that represents a small minority of an organization's business could be addressed over a two-year period, and should not halt all new contracts by that organization. We have the following specific concerns and policy recommendations related to updating the past performance methodology.

First, given the negative impact COVID-19 will have on Star Ratings, we recommend that CMS does not consider low Star Ratings as a determining factor to deny new contract and service area expansions. At a minimum, to avoid penalizing plans for Star Ratings that are not reflective of the current state of performance, we recommend CMS consider at least two years (and preferably three years to align standards across the MA program) of Star Ratings performance to allow for improvement efforts to be measured and reported.

Second, if a contract is low performing a plan may decide not to renew the contract. Therefore, we recommend CMS exclude plans from the past performance review which have been, or will be non-renewed prior to the following contract year. Such a policy would enable plans to refocus efforts on

ensuring existing Medicare contract performance remains at an acceptable level, and expanding high-quality plan choices to beneficiaries' in new service areas.

Third, for CMPs and intermediate sanctions, we ask that CMS recognize these issues may already be resolved by the time they are identified. In addition, upon further investigation the agency may conclude the sanction was unwarranted. As such, we encourage CMS to take a less restrictive approach to updating the past performance methodology and more narrowly tailor the proposal to MA plans with at least two years rather than penalizing plans, and in turn beneficiaries, for an issue that may be an anomaly over a 12-month review period.

Fourth, we also seek clarity on whether the past performance restrictions proposed would apply at the legal entity or the controlling organization level. Anthem would encourage CMS to apply restrictions at the narrower legal entity level, especially if the agency moves forward with the proposed strict evaluation criteria. CMS should consider the size of the identified contract, and plans that impact the controlling organization should have at least enough membership to generate overall Part C and D Star Ratings.

Fifth, given the narrow time frame CMS proposes to review, we also encourage the agency to provide plans with a remediation opportunity and an appeals process. The new proposed policy does not allow for an appeals path whereby a plan can address issues identified over a short period of time that are unlikely to be repeated, when the plan is otherwise capable of delivering high-quality care to beneficiaries moving forward.

Finally, CMS notes that the agency intends to exclude intermediate sanctions imposed on D-SNPs (2021 through 2025) as a basis for denying a MA or Part D application. We appreciate CMS' acknowledgement that given the new requirements of the BBA 2018, more intermediate sanctions may not be tied to overall contract performance.

Call Center Requirements (§§ 422.111 and 423.128)

Recommendation Summary: Anthem supports the codification of existing guidance and standards related to call center operations.

Recommendation Detail: We appreciate CMS' efforts to enumerate more explicit performance standards for MA and Part D customer service call centers, and ensure protections for beneficiaries. Our interpretation of the proposed requirements for call center hours is that CMS is putting into regulation the existing requirements in section 80.2 of the current Medicare Communications and Marketing Guidelines.[38] We encourage CMS to clearly reflect that existing policy in the final regulation.

[38] CMS. "Medicare Communications and Marketing Guidelines (MCMG)." September 5, 2018. https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY2019-Medicare-Communications-and-Marketing-Guidelines_Updated-090518.pdf.

Special Election Periods (SEPs) for Exceptional Conditions (§§ 422.62 and 423.38)

Recommendation Summary: We encourage CMS to consider and clarify SEPs for beneficiaries impacted by public health emergencies like the COVID-19 pandemic. We also request clarification regarding SEPs for D-SNPs, FIDE-SNPs, and HIDE-SNPs to account for varying state Medicaid enrollment timeframes.

Recommendation Detail: Given CMS' proposal to codify a SEP for individuals affected by a FEMA-declared weather-related emergency or major disaster, we encourage CMS to consider a SEP for public health emergencies. The COVID-19 pandemic may impact beneficiaries' ability to make informed Medicare decisions, therefore, we encourage the agency to consider the appropriateness of providing enrollment flexibilities for beneficiaries and their caregivers, and encourage alignment with the Star Ratings extreme and uncontrollable circumstances policies.

CMS also proposes to finalize several Part C and Part D SEPs that are applicable to SNPs. We request that the agency provide additional clarity regarding SEPs for D-SNPs, particularly as states move to FIDE- or HIDE-SNP models, and there may be different state Medicaid enrollment timeframes to take into account.

***

We value the partnership that we have developed with CMS and welcome the opportunity to discuss our recommendations to ensure the delivery of robust benefits and quality care via the MA and Part D programs. Should you have any questions or wish to discuss our comments further, please contact Amanda Hurley at (202) 508-7892, or amanda.hurley@anthem.com.

Sincerely,

Anthony Mader
Vice President, Public Policy

Anthem is a leading health benefits company dedicated to improving lives and communities, and making healthcare simpler. Through its affiliated companies, Anthem serves more than 79 million people, including 41 million within its family of health plans and over 2.5 million Medicare consumers. We aim to be the most innovative, valuable and inclusive partner. For more information, please visit www.antheminc.com or follow @AnthemInc on Twitter.

TAB 8

PUBLIC SUBMISSION

As of: January 25, 2024
Received: April 06, 2020
Status: Posted
Posted: April 10, 2020
Tracking No. 1k4-9fz8-3m12
Comments Due: April 06, 2020
Submission Type: Web

Docket: CMS-2020-0010
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2021 (CMS-4190-P)

Comment On: CMS-2020-0010-0002
Medicare and Medicaid Programs: Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Document: CMS-2020-0010-0502
Comment on CMS-2020-0010-0002

Submitter Information

Name: Sean Creighton
Organization: Humana, Inc.

General Comment

Comments and accompanying documents attached.

Attachments

Humana CY 2021 2022 Proposed Rule 4190P Comments

Wakely Star Rating Variability Analysis Memorandum 20200403_update

Wakely Proposed Rule Star Rating Changes Memorandum 20200323

Humana Inc.
500 W. Main St.
Louisville, KY 40202-2946
www.humana.com

Humana

April 6, 2020

Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Humana Inc. Comments on Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly [CMS-4190-P]

Dear Administrator Verma:

This letter is in response to the Centers for Medicare and Medicaid Services (CMS) request for comments on the Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly [CMS-4190-P] as issued on February 5, 2020.

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. As one of the nation's top contractors for Medicare Advantage (MA) with approximately 4.4 million members and Medicare Prescription Drug Plans (PDPs) with approximately 3.9 million members, we are distinguished by our nearly 35-year, long-standing, comprehensive commitment to Medicare beneficiaries across the United States. These beneficiaries – a large proportion of whom depend upon the Medicare Advantage program as their safety net and many in underserved areas – receive integrated, coordinated, quality, and affordable care through our plans.

Humana is also a direct provider of care for Medicare beneficiaries. We have a 40 percent ownership stake in Kindred at Home which is comprised of 824 home health, hospice and community care programs. Additionally, through joint-venture partnerships and alliances, Humana has interests in over 200 primary care centers.

We highlight the issues below as we believe they have the potential to significantly impact the future direction and growth of the Medicare Advantage program. This program remains the largest, most successful, and comprehensive, integrated care delivery model in Medicare.

Summary of Humana's Key Issues and Recommendations

- **Network Adequacy** – We recommend that CMS finalize the proposed MA network adequacy revisions. We believe the agency's proposals will increase market competition, preserve and expand access to care, and reduce health care costs for beneficiaries and the Medicare program. We further recommend that CMS issue sub-regulatory guidance to implement the network adequacy changes in time for 2021 bids.

- **Network Adequacy for Dialysis Services** – We strongly recommend that CMS adopt one of the following approaches to improve MA network adequacy requirements for dialysis services in advance of ESRD beneficiaries becoming eligible to enroll in MA plans in 2021:

    - Allow plans to attest to providing medically necessary dialysis services in their contract applications, which would significantly improve market competition while still allowing CMS to conduct rigorous oversight of beneficiary access to care as part of the MA plan contract review and approval process; and/or
    - In addition to the 85 percent threshold for all non-urban providers and the 10 percent credit for all providers located in states with certificate of need laws, we ask that CMS finalize the agency's proposal to allow exceptions to time and distance standards if a plan is instead covering home dialysis for all enrollees who need these services. The concurrent adoption of all three policies would preserve rigorous time and distance standards while making reasonable allowances for evolving models of care, such as home dialysis.

- **Stars Rating Program** – In light of the COVID-19 crisis, we urge CMS to refrain from making significant changes to the Star Ratings program at this time. Specific to the recommendations outlined in the proposed rule, we strongly oppose CMS's proposals for the following:
    - Outlier deletion: Removal of outliers prevents the full representation of industry quality performance and unfairly penalizes plans, even though the underlying quality of the contracts has not changed. An attached analysis by Wakely estimates that the proposal would reduce plan payments by $1.4 billion in 2023 – nearly double CMS projections. We recommend that CMS instead adopt a full or partial notice of Stars Ratings cut-points in order to improve the predictability and stability of the Star Ratings program.
    - Patient Experience & Access Measures: While Humana supports CMS's policy goal of encouraging plans to improve patient experience, the proposed changes in weighting inadvertently shift focus away from health outcomes, which runs contrary to the underlying purpose of the Stars program.

Additionally, much has changed since the agency published this proposed rule in the beginning of February. In response to the COVID-19 pandemic in the United States, CMS and the Department of Health and Human Services (HHS) have taken swift action to exercise broad powers through Section 1135 of the Social Security Act to temporarily modify certain requirements of the Medicare program by expanding access to telehealth, supporting providers by minimizing reporting requirements, and focusing on beneficiaries and their needs. CMS also provided extensive flexibilities to MA plans and PDPs through the Interim Final Rule with Comment [CMS-1744-IFC] on March 30, 2020 to allow us to better support beneficiaries and providers during the emergency period. All of these actions taken by

the Administration have been greatly appreciated and we thank the agency for its extraordinary efforts to allow the health system to focus on the most pressing issues at hand.

As a result of these actions, Humana has been able to take extensive steps to care for members during this public health crisis including the following:

- **Waiving consumer costs related to the treatment of COVID-19** as well as FDA-approved medications or vaccines when they become available.

- **Waiving consumer costs related to COVID-19 testing**, including related visit costs in a range of clinical settings such as a physician's office, urgent care center or emergency department.

- **Expanding access to telehealth services** by waiving out-of-pocket costs for services delivered by participating/in-network providers and accepting audio-only telephone visits for reimbursement.

- Allowing **early prescription refills**, so members can prepare for extended supply needs – an extra 30- or 90-day supply as appropriate.

- **Proactively reaching out to members** most at-risk for COVID-19, as identified by their proximity to COVID-19 "hot spots", and those with multiple chronic conditions.

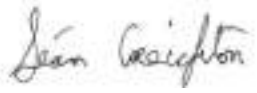
- **Lifting administrative requirements** for the care of all members infected with coronavirus and for all patients in settings where capacity is stretched by the needs of those infected by coronavirus allowing for unencumbered movement from inpatient hospitals to safe, medically appropriate post-acute care settings, including home health, long-term acute care hospitals, skilled nursing facilities, etc.

- Providing a **member-support line** with specially trained call center employees to help support members with specific coronavirus questions and concerns, including live assistance with telehealth.

Once again, we thank CMS for their partnership in providing these flexibilities so that health plans can best serve beneficiaries during this period. We look forward to continuing to work with you to continue to respond to the pandemic and provide the highest level of support for our members and providers.

As always, we value this opportunity to provide comments and are pleased to answer any questions you may have with respect to the comments below. We hope that you consider our comments as constructive feedback aimed at ensuring that together we continue to advance our shared goals of improving the delivery of coverage and services in a sustainable, affordable manner to Medicare beneficiaries, focused on improving their total health care experience.

Sincerely,



Sean Creighton
Vice President, Public Policy

II. Implementation of Certain Provisions of the Bipartisan Budget Act of 2018

Special Supplemental Benefits for the Chronically Ill (SSBCI)

CMS proposes to codify existing guidance and parameters for special supplemental benefits for chronically ill enrollees at § 422.102(f) to implement section 1852(a)(3)(D) of the Social Security Act.

> **Humana comments: Humana supports codifying existing guidance, as it will allow MA plans to anticipate future years' benefit design.** We also appreciate the broad discretion that CMS is allowing plans in developing SSBCI proposals and processes for determining eligible members, particularly the flexibility to consider social determinants, such as food insecurity, social isolation and loneliness, transportation and housing.

CMS proposes to allow MA plans to consider any chronic condition not identified (under section 1859(b)(6)(B)(iii) of the Act) if that condition is life threatening or significantly limits the overall health or function of the enrollee.

> **Humana comments: Humana supports CMS' proposal to allow MA plans to consider any chronic condition that is life threatening or significantly limits the overall health or function of the enrollee.** This flexibility will allow plans to tailor benefits to improve our chronically ill members' health and quality of life.

Improvement to Care Management Requirements for Special Needs Plans (SNPs) (§ 422.101)

Section 50311 of the BBA of 2018 modified the requirements for C-SNPs in section 1859(f)(5) of the Social Security Act. CMS is proposing to extend these requirements to D-SNPs and I-SNPs.

> **Humana comments:** While Humana supports efforts to enhance care of special needs beneficiaries, we have some concerns around broad implementation of the requirements, as detailed below.

CMS proposes the interdisciplinary team include a team of providers with demonstrated expertise, including training in an applicable specialty, in treating individuals similar to the targeted population of the SNP.

> **Humana comments:** Humana acknowledges and supports the importance of including specialty providers within the care team as outlined in the Model of Care; however, Humana is concerned that requiring specialty care teams does not allow the plan to:
>
> - Accommodate care team members due to outside influencing factors:
>   - Focusing on specialty providers does not account for provider shortages or the importance of primary care providers (PCPs). A study conducted by IHS Markit for the Association of American Medical Colleges forecasts a shortage of up to 122,000 physicians in the United States.[1] A shortage of specialists, particularly in rural areas,

[1] The Complexities of Physician Supply and Demand: Projections from 2017-2032, IHS Markit on behalf of the Association of American Medical Colleges, retrieved on March 6, 2020 from https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf

often results in PCPs treating individuals with chronic conditions. PCPs may not have training in an applicable specialty but typically are in the best position to manage a member's overall health. Additionally, evidence reveals that, compared to specialists, PCPs have a greater impact on equitable distribution of health in populations.[2]

- The extent to which plans are able to include providers within care teams is based on information that is not immediately available when a member first joins a plan. For example, the providers with which a member has established relationships may be unknown. In some instances, it is necessary to rely on the availability of claims data to validate a specialty provider's treatment of a member in order to include the provider in the care team. In other cases, a member may not have selected or received treatment from a specialty provider.

- Incorporate clinical judgment of risk needs into the plan of care:
  - Addressing social determinants of health, including access to quality housing, food, and transportation, is a critical component of managing health, particularly that of dual eligible beneficiaries. These needs at times outweigh clinical treatment by a specialist. Humana collaborates with a variety of internal and external care team participants to drive positive health outcomes at the discretion of the primary care manager and member.
  - Members also have the right to refuse the inclusion of specialists within their interdisciplinary care team.

CMS proposes a face-to-face encounter between each enrollee and a member of the enrollee's interdisciplinary team or the plan's case management and coordination staff on at least an annual basis, beginning within the first 12 months of enrollment, as feasible and with the individual's consent.

Humana comments: We support CMS's proposal; however, due to the complexity of implementation, we request that CMS provide clarity around the expectations and exclusions. We believe the following circumstances should be considered when implementing this rule: 1) difficulty monitoring external ICT participants' face-to-face visits; 2) timeliness of claims data for the purposes of validating provider visits; and 3) the feasibility of face-to-face encounters with each member. Humana recommends that health plans be permitted to develop their own technical specifications and identify appropriate member inclusion/exclusion criteria. For example, Humana recommends health plans be allowed to capture verbal confirmation from members/providers of completed face-to-face encounters from external parties and/or telehealth encounters as evidence of compliance. Health plans would then monitor adherence to the regulation using § 422.152 (quality improvement program).

In addition, CMS guidance allows the completion of a Health Risk Assessment prior to the effective date of enrollment. Therefore, we recommend that the new regulation align with previous CMS guidance by allowing face-to-face encounters to be made within 90 days prior to enrollment, instead of only within the first 12 months of enrollment.

[2] Starfield, Barbara, Leiyu, Shi, Macinko, James: Contribution of Primary Care to Health Systems and Health. Milbank Q. 2005 Sep; 83(3): 457–502.

CMS currently allows health plans to offer incentives for Health Risk Assessment completion. If CMS elects to require annual face-to-face encounters with all members, we recommend that plans be permitted to offer incentives for face-to-face encounters to help drive engagement and impact health outcomes.

CMS proposes the results of the initial assessment and annual reassessment required for each enrollee be addressed in the individual's individualized care plan.

Humana comments: Humana supports this proposal. We believe this approach allows for health plans to address the unique challenges our members face and ultimately improve health outcomes. We propose CMS allow health plans to follow the outlined provisions within their model of care. In addition, we suggest health plans be allowed to utilize clinical judgment to evaluate and determine which findings in the assessment should be addressed in the care plan. We believe care plan goals and objectives should be established between the member and care management team based on the wants and needs of the member.

CMS proposes as part of the annual evaluation and approval of the SNP model of care (MOC), the National Committee for Quality Assurance (NCQA) must evaluate whether goals were fulfilled from the previous model of care and plans must provide relevant information pertaining to the MOC's goals as well as appropriate data pertaining to the fulfillment of the previous MOC's goals.

Humana comments: We support CMS's efforts requiring health plans to include discussions around performance of previous year's goals in the model of care. However, we are concerned about the ability of plans to have year-end data available prior to February submission of MOCs. Health plans evaluate their quality improvement program shortly after the end of the year when all data is complete and available. This leaves very little time to access data to incorporate results in the annual and renewal MOC submissions due in February. Humana recommends CMS allow submission of a portion of the annual data or push back the submission deadlines for renewals to allow for a more accurate and robust discussion around performance goals and changes to those goals.

Humana also recommends focusing the discussion on goal performance to the most current year for those D-SNPs and I-SNPs receiving a two- or three-year approval. As part of the annual evaluation of the model of care from year to year, metrics and goals often change based on performance and the changing needs of the SNP population. If CMS were to allow health plans to only focus on the most current year's goals, it would help facilitate a better discussion on the model of care performance and changes needed to improve member's health outcomes in the upcoming renewal of the model of care. We are assuming health plans will be able to continue to update and modify quality metric goals and performance results based on current CMS regulations pertaining to non-reportable changes in the MOC.

In addition, as part of the MOC quality measurement and performance improvement process, health plans are required to measure and report performance under the plan using standard measures required by CMS. NCQA has communicated verbally standardized goals (HRA, ICP, ICT) for the model of care should be set at 100 percent during previous NCQA/CMS annual model of care training. Influencing factors such as severe weather events, system outages, human/clerical errors, epidemics, population needs or population risk adjustments contribute to goal

performance. Humana is recommending that CMS allow health plans to identify the metrics meeting the needs of their target population and set goals that take into consideration influencing factors rather than set goal expectations at 100 percent.

CMS proposes each element of the MOC must meet a minimum benchmark of 50 percent of total points allotted and a plan's MOC would only be approved if each element of the MOC meets the applicable minimum benchmark.

Humana comments: Humana supports CMS's intent of having standardized reviewing and scoring methods for all SNP plans to reduce the operational complexity for MA plans providing different SNP types. In light of the significant changes to the structure and scoring of annual and renewal MOCs, Humana recommends NCQA hold early MOC training for the 2022 MOC submissions to ensure health plans have sufficient time to develop a robust, compliant MOC.

Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes (§ 422.514)

CMS is proposing at § 422.514(d) to not enter into or renew a contract for a D-SNP look-alike in any state where there is a D-SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals.

Humana comments: Humana commends CMS for its continued focus on integrating coverage and care for dually eligible individuals and helping to navigate differing elements of the Medicare and Medicaid programs for this population. We appreciate that CMS recognizes that dually eligible individuals can best be served under a number of different options based on personal preference as well as state programmatic variations. **Humana encourages CMS to continue to promote consumer choice and provide dually eligible beneficiaries with an array of plan options, including integrated D-SNPs and/or Medicare-Medicaid Plans (MMPs) that fully integrate care as well as other less integrated options for partial duals and those who prefer to enroll in Medicare Advantage plans that are not affiliated with a DSNP or a Medicaid companion plan.** Dual eligible beneficiaries should have the freedom to determine which plan best meets their health care needs based on their specific circumstances. While enrollment in a D-SNP is limited to individuals eligible for both Medicare and Medicaid, the statute does not require that dual eligibles receive their coverage under a D-SNP plan or other integrated Medicare-Medicaid arrangement. **Limiting beneficiary access to non-D-SNP plan designs that prove attractive to dual eligible beneficiaries unnecessarily restricts beneficiary choice.** We are unaware of any evidence demonstrating that D-SNP enrollment has been disrupted by so-called D-SNP look-alike plans; rather, total D-SNP enrollment has more than doubled from one million in 2010 to 2.6 million in 2019.[3] Only a small portion, 1.2 percent, of traditional MA plans have dual eligible populations that comprise 80 percent or more of total plan membership.[4]

Given the small footprint of high density dual eligible enrollment in MA plans, and the lack of evidence demonstrating that the prevalence of so-called D-SNP look-alike plans leads to increased consumer confusion, member dissatisfaction, and/or results in lower quality of care,

[3] Centers for Medicare & Medicaid Services. *SNP Comprehensive Report* (July 2010 & July 2019). Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data

[4] *June 2019 MedPAC Report to Congress Chapter 12* http://medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0

we request that CMS preserve beneficiary choice and not move forward with this restrictive proposal. In lieu of the strict prohibition on MA plan options for dually eligible individuals, we recommend that CMS start by establishing new sales and marketing protocols for Medicare plans when brokers or other sales agents are selling coverage to the dually eligible. For example, such standards could require that all options are presented, including D-SNPs and MMPs (where available) to ensure that beneficiaries are making informed choices and are not unknowingly enrolling in a "look alike" product.

Notably, based on our experience, dually eligible enrollees with access to either D-SNPs or MMPs often make conscious choices to elect non-D-SNP Medicare Advantage plans, regardless of whether they are considered a D-SNP look-alike. This is particularly evident for partial duals, 64 percent of whom were enrolled in traditional MA plans in 2016.[5] A large percentage of full duals passively enrolled in MMPs also have indicated a preference for choice by exercising opt-out privileges (41 percent between October 2013 and April 2016).[6] This evidence supports the desire and need to continue providing enrollees various choices, rather than limiting them. While CMS concludes that cross-walking dual eligible members to other $0 premium general enrollment plans in the same service area would be not be disruptive to these members, none of the other available plans will have the specific plan designs that each beneficiary actively chose – including cost-share structure for A/B benefits and supplemental benefits. Conversely, we believe that loss of access to a variety of desirable supplemental benefits under some non-D-SNP Medicare Advantage plans not only disregards the beneficiary's choice, but may create barriers to care due to lack of access to transportation and other supplemental benefits that help to address social determinants of health.

In a December 3, 2018 letter to President Trump, leaders from HHS, the Department of Transportation, and the Department of Labor commended steps the Administration has taken to address regulations that stifle competition and limit choice, and encouraged additional action, stating, "Health care markets could work more efficiently and Americans could receive more effective, high-value care if we remove and revise certain federal and state regulations and policies that inhibit choice and competition."[7] Imposing enrollment thresholds based on Medicaid eligibility status could have the unintended consequence of limiting choice and competition among MAOs. D-SNPs may not be the best plan option for all dual eligible beneficiaries. Although a substantial percentage of dual eligible beneficiaries benefit from the integration of benefits and care coordination provided by both programs, many do not need or desire a high level of intervention. Additionally, partial duals do not benefit directly since they are not eligible for Medicaid benefits.

CMS proposes to establish a new regulation precluding CMS from entering into or renewing a contract for an MA plan that an MA organization offers, or proposes to offer, with enrollment of dually eligible

[5] June 2018 MedPAC Report to Congress Chapter 9, p. 279; http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf?sfvrsn=0

[6] June 2018 MedPAC Report to Congress Chapter 9, p. 252; http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf?sfvrsn=0

[7] Reforming America's Healthcare System Through Choice and Competition, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, U.S. DEPARTMENT OF THE TREASURY, U.S. DEPARTMENT OF LABOR; December 3, 2018; https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html

individuals that exceeds specific enrollment thresholds. This proposed regulation would apply in any state where there is a D-SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals.

> **Humana comments:** Humana applauds CMS for their continued efforts to protect vulnerable populations; however, **we feel the proposed regulation would negatively impact dually eligible individuals who reside in states where D-SNPs are offered, but are not yet available in specific service areas and/or do not cover all dual eligible categories.** In 2019, there were over 250,000 dual eligibles residing in 381 counties within the United States in which D-SNPs were allowed in the state but were not offered in the specific county.[8]
>
> It is also customary for many State Medicaid Agency contracts to only cover certain dual eligible categories, the most significant being Qualified Medicare Beneficiary (QMB) and QMB+, which could leave many dually eligible enrollees unable to enroll in a D-SNP, even if offered in their service area because the D-SNPs offered do not cover their subset population. We urge CMS to protect this vulnerable population by ensuring the availability of attractive plan options that are tailored to this population's needs.
>
> **If CMS elects to move forward with the proposal despite the concerns raised in our comments, we request that the agency apply any applicable threshold at the county level – not the state level.** Humana further recommends that CMS apply thresholds only to plans offered in counties where D-SNPs and/or MMPs are available. In addition, we recommend that CMS only include dual eligible categories that are covered under the D-SNP contracts in those counties when determining if a plan is at or over the threshold.

CMS proposes to establish procedures for transitioning enrollees from D-SNP look-likes to other MA plans in new regulation text at § 422.514(e). The proposed new contracting standards would effectively ensure all MA plans that predominantly serve dually eligible individuals integrate delivery of Medicare and Medicaid services and coordinate care consistent with the statutory and regulatory requirements for D-SNPs wherever it is feasible to do so.

> **Humana comments: As detailed above, we strongly believe that CMS should preserve beneficiary choice and not limit the plan options available to dual eligible beneficiaries.** If CMS ultimately elects to move forward despite these concerns, we urge the agency to apply the 80 percent or more threshold based on dual eligible categories covered under the D-SNPs available in the service area of the plan, rather than using all enrollees entitled to medical assistance under a state plan under Title XIX, since not all enrollees would have access to the available D-SNPs in the service area. For existing plans identified as meeting or exceeding the 80 percent threshold, MAOs should have the ability to crosswalk members to new plans based on dual eligible status, chronic condition and other factors as necessary to ensure members are placed in a plan that best fits their needs. We appreciate CMS giving plans the ability to crosswalk non-D-SNP members into D-SNP across legal entities and believe cross-walking across legal entities should be available in other situations where it would be in the members best interest (e.g. cross-walking a member with a chronic condition into a C-SNP under a different legal entity).

[8] Milliman Medicare Advantage Competitive Value Added Tool 2020, Version 1.01, Fall 2019 Release; CMS Enrollment Snapshots Quarterly Release, County, March 2019 <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics>

However, while we appreciate CMS giving plans the ability to crosswalk non-D-SNP members into D-SNPs across legal entities, **we are concerned there could be disproportionate and unintended impacts to the Members Choosing to Leave the Plan Star Rating measure for plans who crosswalk members from a non-D-SNP to a D-SNP under different contracts within the same parent organization.** We do not believe this measure, which is representative of member satisfaction, would accurately reflect performance if cross-walked members are included in the measure. We therefore request CMS ensures that all proposed member transitions under this section are excluded from the Members Choosing to Leave the Plan measure. We also urge CMS to provide clarity regarding whether cross-walking members across various plan types (e.g. Health Maintenance Organization (HMO) to Preferred Provider Organization (PPO)) is allowed.

Implementation of Several Opioid Provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act

Mandatory Drug Management Programs (DMPs) (§ 423.153)

The SUPPORT Act made changes to the requirements for Part D DMPs to enhance Part D sponsors' ability to reduce the abuse or misuse of opioid medications in their prescription drug benefit plans. CMS is proposing three corresponding changes to the Part D DMP provisions: 1) requiring Part D sponsors to adopt DMPs on or after January 1, 2022; 2) requiring the inclusion of Part D beneficiaries with a history of opioid-related overdose in sponsors' DMPs beginning January 1, 2021; and 3) creating an additional category of exempt beneficiaries, patients with sickle cell disease starting January 1, 2021.

Humana comments: Humana supports CMS' mandate of plan sponsors to have an operational DMP by 2022. Humana voluntarily developed a DMP, which has been operational since January 2019.

Humana encourages CMS to consider grandfathering beneficiaries who have existing beneficiary-specific, point-of-sale limitations in place from before DMPs were implemented in 2019. We recognize that CMS has issued guidance stating that these members will continue in their current limits unless they meet Overutilization Monitoring System (OMS) criteria. To date, we have approximately 370 members who fall into this category. Currently, Humana monitors this beneficiary cohort under rules (including program exclusions) and guidance separate from the DMP membership. This creates undue burden on the plan to continue to follow two groups of beneficiaries under two very different sets of rules. Information on these beneficiaries is not communicated via the Medicare Advantage Prescription Drug (MARx) System or the Transaction reply Report (TRR), therefore these beneficiaries are lost to follow up when they change plans and CMS is no longer able to track them. We suggest that these members be enrolled in the current DMP regardless of if they meet the current OMS criteria. This would allow for each beneficiary cohort to be managed by the same set of guidelines for exclusions, member notices, inter-plan sharing and end dates of limitations.

Humana also supports the exclusion of members with a diagnosis of sickle cell disease for plan year 2021 from the DMP. Patients with sickle cell disease are a patient population for which it is extremely hard to adequately manage their pain, therefore we do not feel they should be included in DMPs.

Beneficiaries with History of Opioid Related Overdose Included in DMPs (§ 423.100)

CMS is proposing to modify the definition of "Potentially At Risk Beneficiaries" (PARBs) to include patients who have had an opioid-related overdose. CMS proposes to define "history of opioid-related overdose" to mean that for the Part D beneficiary, a recent claim has been submitted that contains a principal diagnosis code reflecting an opioid overdose, regardless of the type of opioid, and at least one recent prescription drug event for an opioid dispensed has been submitted in the past 6 months.

> **Humana comments: Humana commends CMS for expanding the definition of "opioid-related overdose" to include overdoses occurring from prescription or illicit opioids.** We support any additional means by which PARBs can be identified and included in DMPs. However, it has been well documented that opioid-overdose diagnoses and opioid-use disorders are vastly under coded in general.[9,10] While it is recommended that opioid-related overdoses are coded as the principal diagnosis, overdoses are still frequently coded in the secondary and tertiary diagnosis positions on the medical claim. We feel that the reliance on only utilizing the principal diagnosis code to capture an opioid overdose may result in missed opportunities to identify PARBs. Research has demonstrated that examining both the principal and secondary diagnoses codes increases the identification of opioid-overdose cases.[11,12] Internal Humana data has identified opioid overdoses in the secondary diagnosis position among approximately 25 percent of the cases. Additionally, Humana identified 2,552 beneficiaries with opioid overdoses across all diagnosis positions.
>
> **We recommend that CMS expand the definition for identifying opioid overdose cases to include both the principal and secondary diagnosis position on the medical claim.** Additionally, we would like CMS to reconsider the definition of an opioid-related overdose, which as proposed requires the patient to have had an opioid prescription drug event (PDE) in the previous six months. Internally at Humana, we identified that one-third of opioid emergency department adverse drug events could not be attributed to an opioid claim, which means opioid overdoses could be attributed to things like taking other individuals' medications, medication non-adherence, cash-paying opioid members, or other indications of aberrant use. We feel that we would be missing out on an important opportunity to intervene on a high-risk cohort if we require there to be an opioid fill in the previous six months. **Regardless of the indication of an opioid PDE in the previous six months, if the beneficiary has an opioid-related overdose Humana will still need to manage these patients and provide appropriate care; therefore excluding those without an opioid claim will limit our clinical management of patients with potential at-risk status.** We recommend removing the requirement of an opioid PDE in the six months prior to the overdose event.

CMS seeks comments on whether this proposal needs additional features to facilitate the case management process for PARBs with a history of opioid-related overdoses and the sponsor-provider communication process.

---

[9] Kim HM, Smith EG, Stano CM, et al. Validation of key behaviourally based mental health diagnoses in administrative data: suicide attempt, alcohol abuse, illicit drug abuse and tobacco use. BMC Health Serv Res. 2012 Jan 23; 12():18.

[10] National Center for Health Statistics. Ambulatory care use and physician office visits. Available at: https://www.cdc.gov/nchs/fastats/physician-visits.htm. Accessed March 20, 2019.

[11] Slavova S, Bunn TL, Talbert J. Drug overdose surveillance using hospital discharge data. *Public Health Rep*. 2014;129:437–445.

[12] Denham A, Mullaney T, et al. Are Increasing Trends in Opioid-Related Hospitalizations Attributable to Increases in Diagnosis Recordability? Evidence from 2 Large States. Health Services Insights. 2019; 12: 1–9.

Humana comments: We would encourage CMS to provide plan sponsors with specific claim information, such as the date of claim, provider information (location, type of facility that filed the claim) for each incident. We also request CMS to provide claims (Part A and Part B) for PARBs. In instances where the member has a PDP-only plan, which represents 50 percent of beneficiaries in our DMP program, or is new to the MAPD plan, the plan would not have any specific information to discuss with prescribers during their outreach. This has potential to create undue burden to providers as they would then have to spend additional time researching this information. We fear that by only providing vague details of the incident, the prescriber could abruptly discontinue medications or treatment, which is not the intent of the program.

Plans having access to the full claims information, rather than a yes/no indicator as is being proposed (similar to the benzodiazepine concurrent use in the OMS report), would allow for having full case details discussions with providers, enabling the prescriber to retrieve medical records and directly address the issue with the member. Additionally, providing plans with the full details of the opioid-related overdose claim will greatly enhance the value of plan-provider communication and ultimately, the health and safety of the member.

Model beneficiary notices, provided by CMS, will need to be reviewed to incorporate language specific to a PARB having a history of opioid-related overdose. Plan sponsors may need to update their DMP prescriber written communications to include history of opioid-related overdose as a reason for a beneficiary meeting the OMS criteria.

Humana comments: While we do not feel that mandated CMS language is necessary to conduct case management for this population, we would welcome guidance and sample language that CMS feels would be appropriate for discussing this topic with a prescriber, given that it can often be sensitive in nature. **We do however, support educational efforts provided by CMS to reinforce with prescribers the importance of not abruptly stopping treatment in this patient population, as well as providing appropriate pain management where clinically warranted.**

Humana supports CMS changing the initial written notice and the second written notice that plans send to beneficiaries when they have been determined to be an at risk beneficiary (ARB). We also highly recommend CMS publish the new notices for public comment prior to implementation. Humana suggests that CMS also incorporate the following changes to these notices:

- Initial notice:
  - Page 2, “What is a Drug Management Program”
    - Humana requests that the word “addiction” be replaced with “opioid use disorder” or “substance use disorder” in an effort to reduce stigma with this beneficiary population and become aligned with current evidence-based treatment terminology. We encourage CMS to use current destigmatizing terminology in any updates that are made to beneficiary notices.
  - Page 5, Pharmacy and Prescriber Selection Form
    - Humana requests that CMS allow for the inclusion of this form as optional. We suggest that this form only be included when the member has a pharmacy or a prescriber limitation pending. This form has created confusion for several Humana members who believed they needed to

complete and return the form, even when the form does not apply to the individual case (i.e., where their medications only are being limited, not their provider or pharmacy). This creates a negative member experience with the DMP because the beneficiary does not understand that the plan is unable to modify the notices.
        - We also encourage CMS to rephrase "I prefer to use the following pharmacy (choose two)" to "I prefer to use the following pharmacy (choose up to two)." Beneficiaries has stated that they feel that they must list two pharmacies, when in fact they do not. This vague wording creates confusion for the member that the DMP staff must then explain.
- Second notice:
    - Page 2, "Why Did We Make This Decision?"
        - Humana requests that the word "addiction" be replaced with "opioid use disorder" or "substance use disorder" in an effort to reduce stigma and become aligned with current evidence-based treatment terminology.
    - Page 6, Pharmacy and Prescriber Selection Form
        - Humana requests that CMS allow for the inclusion of this form as optional. We suggest that this form only be included when the member has a pharmacy or a prescriber limitation pending. This form has created confusion for several Humana members, who believed they needed to complete and return the form, when the form does not apply to the individual case (i.e., where their medications only are being limited, not their provider or pharmacy). This creates a negative member experience with the DMP because the beneficiary does not understand that the plan is unable to modify the notices.
        - We also encourage CMS to rephrase "I prefer to use the following pharmacy (choose two)" to "I prefer to use the following pharmacy (choose up to two)." Beneficiaries have stated that they feel that they must list two pharmacies, when in fact they do not. This vague wording creates confusion for the member that the DMP staff must then explain.

<u>Beneficiaries' Education on Opioid Risks and Alternative Treatments (§423.128)</u>
Under the SUPPORT Act, for plan year 2021, Part D sponsors must disclose to a subset of enrollees being treated for pain who have been prescribed an opioid in previous two years, info on the risks of prolonged use, and disclose coverage of non-pharmacological therapies, devises and non-opioid meds under their plan.

> **Humana comments:** Humana appreciates CMS' recommendation of proposed cohorts to target for providing educational outreach on opioid risks and alternative treatments. We will take these examples into consideration when determining which cohorts to target based on the needs of our unique patient population.

<u>Eligibility for Medication Therapy Management Programs (§ 423.153)</u>
CMs proposes to expand the population of beneficiaries who are targeted for MTM program enrollment ("targeted beneficiaries") to include at-risk beneficiaries (ARBs), and by adding a new service component requirement for all targeted beneficiaries.

Humana comments: Humana's MTM program has been an integral part of our Medicare Part D drug utilization management strategy. We applaud CMS for recognizing the role that MTM-type interventions could play in reducing ARBs risk for opioid overuse and adverse opioid-related events and welcome additional opportunities to intervene with individuals at risk. **However, Humana encourages CMS to re-evaluate how MTM for this patient population would be different from the traditional Medicare Part D MTM program, as ARBs have different medication-related needs**. The majority of ARBs do not otherwise meet the existing Part D MTM Program enrollment criteria based on chronic conditions, number of medications utilized, and drug spend; therefore, a traditional Comprehensive Medication Review (CMR) intended to evaluate the use of multiple medications may not be as impactful for this cohort of patients. CMS has also reported an estimated 87 percent CMR acceptance rate among ARBs (under DMP definition) in the current MTM program, however we believe the actual acceptance rate will lower in the ARB cohort. Our internal data suggests that the completion rate is lower among current MTM-eligible beneficiaries who also meet the criteria for ARB under DMPs. The completion rate among these beneficiaries is estimated to be 23 percent. Additionally, 88 percent of the ARB population would be new to our MTM program and would not meet current MTM eligibility criteria. We also seek further clarification from CMS on whether the CMR completion rate for beneficiaries in the DMP would impact the overall plan STAR ratings.

The ARB DMP population has very specific issues that need to be addressed, such as provider shopping behavior, overdose risk, and realistic expectations for activities of daily living with a manageable pain level. We feel that ARBs could benefit from targeted medication review (TMR) type interventions, which leverage a more beneficiary and medication-specific approach to resolving potential medication therapy problems. **To that end, we encourage CMS to defer automatically enrolling DMP members into the traditional Part D MTM Program and allow the plan DMPs to incorporate member outreach and education into the existing DMP.** While this patient population historically has low engagement in outside programs, we believe they would be more likely to engage with clinicians in the DMP with whom they have already had interactions. Additionally, DMP clinicians have established contact with the ARB's providers and have discussed the individual patient's case (hesitation to taper, resistance to fill naloxone, etc.), which could reduce provider burden. DMP staff would be able to address the medication-related issues with the patient and increase their overall health and outcomes. By allowing the DMP staff to conduct educational or TMR-services, the DMP will have the ability to bring the patient full circle in the program and truly offer a chronic care program. Humana welcomes the opportunity to develop a pilot for this concept if CMS deems one necessary. Humana will continue to utilize the Traditional MTM Program opioid-related TMRs to educate MTM-eligible beneficiaries on opioid risks and the safe disposal of medications. If DMP beneficiaries were automatically enrolled in the MTM program, we estimate it would require an additional 2,704 hours of labor. We believe these resources would be better allocated directly to services provided by the DMP.

CMS also proposes a new requirement that Part D plans provide beneficiaries enrolled in their MTM program with information about the safe disposal of prescription drugs that are controlled substances, including information on drug takeback programs, in-home disposal, and cost-effective means for safe disposal of such drugs. Summaries can be mailed as part of CMR summary or as part of TMR or other follow up service.

Humana comments: Humana supports providing MTM enrollees with information on the safe disposal of controlled substances. Humana requests CMS to clarify how it plans to enforce this section of the SUPPORT Act and how plans will need to demonstrate compliance.

Automatic Escalation to External Review under a Medicare Part D Drug Management Program (DMP) for At-Risk Beneficiaries (§§ 423.153, 423.590, 423.600)

CMS proposes that if on reconsideration a Part D sponsor affirms its denial of a DMP appeal, the case shall automatically be forwarded to the IRE for review and resolution.

Humana comments: Humana supports CMS' proposal of automatically forwarding DMP appeals to an IRE for review and resolution. It has been our experience in general that most patients do not formally contest their at-risk determination status; however, we support a beneficiary's right to appeal through due process.

Suspension of Pharmacy Payments Pending Investigations of Credible Allegations of Fraud and Program Integrity Transparency Measures (§§ 405.370, 422.500, 422.503, 423.4, 423.504, 455.2)

CMS is proposing to implement sections of the SUPPORT Act, which will require Part D plan sponsors to notify the HHS Secretary of the imposition of a payment suspension on pharmacies that is based on a credible allegation of fraud, impose such payment suspensions consistent with the manner in which CMS implements payment suspensions in fee-for service Medicare. Prior to any payment suspension, plans would be required to give a CMS 14-day prior notification.

Humana comments: Humana appreciates the efforts the current Administration has made in combating fraud, waste, and abuse (FWA) across CMS' programs and the ongoing collaboration with plan sponsors. Given the magnitude of FWA which has contributed to the opioid epidemic, we welcome new strategies for Part D plan sponsors to address the epidemic and detect and deter fraudulent billing and payment. **However, we do have concerns regarding the requirement of a 14-day notification period to CMS prior to implementation of the payment suspension.** We believe that this will result in unintentional consequences that may arise during this waiting period, such as unnecessary costs to both the plan and the Medicare Program, as well as the provision of further acts of FWA. We are requesting further clarification from CMS around the justification for the 14-day prior notification requirement and what actions CMS will take during this time. We request that CMS also provide further information and clarity on the approval or authorization process at the end of the 14-day waiting period and how information and final determinations will be communicated to plan sponsors.

Humana endeavors to provide 30 days' notice to pharmacies and impacted members of a pharmacy's termination. There have been situations where pharmacies increase their FWA activities, including large increases in fraudulent billing, during this notice period. For example, Humana recently provided 30 days' notice of termination to a pharmacy because Humana's review of the pharmacy's purchasing records indicated that the pharmacy billed Humana for more drugs or supplies than it actually purchased and Humana received complaints from members that they were not familiar with the pharmacy and never had prescriptions filled at the pharmacy. During the termination notice period, there was a spike in billing from the pharmacy in the amount of $2.3 million dollars. Humana suspended payment to the pharmacy and conducted an investigation. Humana's investigation concluded that the claims were invalid. If Humana had not suspended payment to the pharmacy, it is very likely the pharmacy would

have received payment and Humana would not have been able to recover those funds from the pharmacy.

We are requesting to allow for the immediate suspension of payments to pharmacies suspected of FWA and then provide the referral to CMS within 14 days, or an expedited timeline. We believe that imposing immediate payment suspensions is the most effective way of combatting FWA. We recommend that, especially in the instance of claims that do not meet the definition of "clean" claims (claim has defects or impropriety or special circumstance, including incomplete documentation and does not meet the definition of 'prompt payment' and does not include a claim from a provider who is under investigation for fraud, waste and abuse or a claim is under review for medical necessity[13]), plans should have authority to stop immediate payment to these pharmacies.

HHS will provide guidance quarterly to plans on definitions of fraud, waste or abuse and inappropriate prescribing with respect to opioids.

Humana comments: Humana would like CMS to implement provisions that would allow for the immediate removal of a pharmacy from a network, after investigation of substantiated suspicious activities of FWA is established. Plans need to be able to act expeditiously to protect themselves, their enrollees, and federal fiscal resources.

CMS welcomes public comments on specific populations or diagnosis that could be excluded for purposes of legitimate clinical scenarios that necessitate a higher level of opioid prescribing.

Humana comments: In instances where the plan sponsor is investigating claims for Part D only beneficiaries for FWA cases and for opioid-related case-management, we request that plans be provided access to comprehensive claims data (Part A and B, or MA encounters) in the portal when available. For plan sponsors to conduct complete investigations of potential inappropriate dispensing of prescriptions, or to validate legitimate medical need for Part D only patients, additional medical claims verifying diagnosis are warranted.

CMS proposes to revise the definition of "credible allegation of fraud" and solicit comment on changing definition from "fraud hotline complaints" to "fraud hotline tips verified by further evidence." New proposed definition: "a credible allegation of fraud is an allegation from any source including, but not limited to: fraud hotline tips verified by further evidence; claims data mining (prescription drug events and encounter data mining); patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability."

Humana comments: Humana agrees with the proposed definition of a "credible allegation of fraud." Humana currently further investigates all hotline complaints with additional data verification and recommends this as a best practice.

[13] Title 42. Public Health. Chapter IV. CMS, Department of Health and Humana Services. Subchapter C Medical Assistance Programs. Part 447 Payment for Services. Subpart A. Payments: General Provisions. Section 447.45 Timely Claims Payment.

HHS welcomes comments on specific populations or diagnoses that could be excluded and reasonable measures of inappropriate prescribing of opioids and other reasonable measures of inappropriate prescribing of opioids.

> **Humana comments**: Humana recommends implementing the same exclusions as those applied to the DMP for consistency, such as cancer, hospice, palliative care/end of life, long term care facility resident, assisted living facility contracted by one pharmacy, and sickle cell disease starting in 2021. The provision of Part C claims through the secure portal would be beneficial in the verification of patient's diagnosis information.

Implementation of Certain Provisions of the 21st Century Cures Act, Part C. Exclusion of Kidney Acquisition Costs From Medicare Advantage (MA) Benchmarks (§§422.258 and 422.306)
Section 17006(b) of the 21st Century Cures Act amended sections 1853(k) and (n) of the Social Security Act to exclude the agency's estimate of the standardized costs for payments for organ acquisition for kidney transplants from MA benchmarks starting in 2021. In order to compute the county-level costs to be excluded from MA benchmarks, CMS performed certain steps as described in the Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies ("Advance Notice"), Part II.

> **Humana comments:** Starting on page 24, the CY2021 Advance Notice Part II describes the MA ratebook adjustments mandated by the 21st Century Cures Act for kidney acquisition costs (KAC). It further states that the Act requires FFS to cover KAC for MA beneficiaries and that MA plans will not be required to provide KAC coverage for its enrollees.
>
> **Humana requests that CMS make available the data, including county-level utilization and unit costs, that the agency used to develop the county level KAC carve-out amounts.** Providing this data will give MAOs access to information that may not be apparent in their data and allow them to evaluate the methodology CMS used to exclude KAC costs from the payment benchmarks.
>
> According to the limited data that CMS has provided, tables 26 and 27 in Proposed Rule CMS4190-P show that there were approximately 75,000 kidney transplants paid by FFS during 2014-2018, the data period used to compute the KAC carve-out amounts. Humana has concerns about the credibility of using 75,000 events to develop 3,225 county specific carve-out factors. **If CMS elects to implement such carve-out factors, we ask that they be developed across broader geographic areas than counties in order to mitigate the high variability and potential credibility issues that may exist when forecasting future county level carve-out amounts.**

While CMS-4190-P does not contain implementation details concerning ESRD beneficiaries enrolling in MA plans, Humana would like to take this opportunity to comment on some of its concerns with respect to details that have been published in other CMS documents.

CMS is proposing to continue to apply in large part the same methodology as in previous years in calculating the MA ESRD state rates for CY2021. Organ acquisition costs will be excluded from the benchmarks beginning with CY2021 per the requirements of the 21st Century Cures Act. CMS will begin publishing a file with the CY2021 Rate Announcement that includes the key components of the rate development, similar to the rate calculation data supporting the MA non-ESRD county rates. CMS has also proposed separately in CMS-4190-P to improve MA network adequacy requirements for dialysis services in advance of ESRD beneficiaries becoming eligible to enroll in MA plans in 2021.

Humana comments: We appreciate that CMS will begin publishing a file to make available the details on the calculation of ESRD state rates, similar to non-ESRD county rates. We also appreciate the proposals aimed at improving MA network adequacy requirements for dialysis services, and we strongly recommend that CMS finalize those proposed changes in advance of the CY2021 bid submission deadline.

However, Humana has concerns that the changes proposed for CY2021 to account for the increased cost to Medicare Advantage Organizations (MAOs) from enrollment of ESRD beneficiaries comes at a cost to non-ESRD members, such as:

- Using MA rebate dollars, normally used for benefit enhancements such as reduced cost sharing and Mandatory Supplemental Benefits, to cover ESRD costs included in the bid via the ESRD subsidy section in Worksheet 4 of the MA Bid Pricing Tool,
- MOOP limit increases that apply to all members regardless of ESRD/non-ESRD status, and
- Increases in Part C cost sharing limits that also apply to all members, regardless of ESRD/non-ESRD status. For example, proposed changes in Part C cost sharing for "Inpatient Hospital Acute - 60 Days" would result in maximum cost sharing that exceeds 100 percent of the Medicare FFS cost sharing for individuals without ESRD.[14]

Rather than increasing costs for all non-ESRD beneficiaries, Humana recommends that CMS instead adjust the ESRD dialysis benchmarks to account for the significantly higher plan cost due to MOOP requirements.

As CMS has acknowledged, ESRD beneficiaries incur significantly higher claims costs, and incur more costs past the MOOP threshold, compared to non-ESRD beneficiaries.[15] Accordingly, we recommend that CMS adjust the ESRD State Rates to reflect the impact of MOOP, an update that we believe the 21st Century Cures Act gives CMS the statutory authority to do. The intent of the 21st Century Cures Act is to permit the enrollment of ESRD beneficiaries into MA plans. Such an adjustment to payment benchmarks would more closely align with congressional intent by allowing MAOs to continue offering their current level of benefits as well as to maintain their broad geographic participation. CMS proposals for CY2021 instead spread the additional cost of ESRD beneficiaries over the non-ESRD population, potentially resulting in higher member cost sharing and/or fewer supplemental benefits for all beneficiaries.

We appreciate that in CMS-4190-P, CMS shared their projection of the magnitude of ESRD migration from Original Medicare to Medicare Advantage in 2021 and in future years. Additionally, we thank OACT for providing, in the February User Group Call Actuarial Bid Questions document, a projection of the financial impact of ESRD migration from Original Medicare to MA.[16] While we acknowledge that CMS must use the data available, we would like to highlight several concerns with the calculations and assumptions in the development of the estimated -$0.23 PMPM impact to the overall MA plan margin from ESRD migration to MA in 2021:

[14] CMS Memorandum: Contract Year 2021 Part C Benefits Review and Evaluation. Kathryn A. Coleman, February 6, 2020.

[15] Ibid.

[16] https://www.cms.gov/files/document/cy-2021-actuarial-bid-questions.pdf-1

- The Worksheet 1, Section V data that CMS is using represents the entire ESRD block of MA business, including Dialysis, Graft, and Post-Graft members. We believe this population is not representative of Original Medicare ESRD beneficiaries likely to migrate to MA plans in 2021 for the following reasons:
  - The financial incentives for ESRD beneficiaries to migrate to MA are much greater for those in dialysis status than in post-graft status, particularly the MOOP benefit. While dialysis beneficiaries represent 75-80 percent of the ESRD population, we anticipate the composition of ESRD migrants will be disproportionately weighted to the dialysis population. As dialysis enrollees experience a much higher Medical Loss Ratio (MLR) than the overall ESRD population, due in part to the impact of the mandatory MOOP, using the experience of the entire ESRD population to estimate the experience of the 2021 ESRD migrants underestimates the impact to MA plan margin.

  - Within the dialysis population, we believe that the lack of available affordable Medicare Supplement coverage for ESRD beneficiaries under age 65 without dual Medicaid eligibility will result in the under 65, non-dual dialysis population migrating to MA at higher rates than other Original Medicare dialysis beneficiaries. Under 65 non-dual ESRD-Dialysis members have higher MLRs than the overall ESRD-Dialysis population. This should be taken into account when determining the financial impact of ESRD migration into MA.

- CMS estimates that the 2020 MLR for ESRD migrants will be approximately 94 percent ($6,919.63 / $7,344.54). Using the revenue and claims trends included in the calculations (9.28 percent revenue, 5.52 percent claims), this implies that the 2018 experience included in Worksheet 1 Section V would have shown an MLR of 98 percent ($6,557.65 / $6,720.84). We believe the 98 percent MLR in 2018 is more representative of future experience for the entire ESRD block than the 94 percent projected for 2020. We also believe for the reasons stated above that the entire ESRD block is not representative of the migrating block, and therefore the migrating block should experience an MLR in excess of 98 percent.

  Additionally, the revenue projection of 9.28 percent does not capture changes in risk scores due to the 2019 revisions of the ESRD Risk Adjustment Model. We are not aware of CMS having published any estimates of the aggregate impact to plan risk scores from this revision. If CMS has performed such an analysis, we encourage the agency to include this assumption in its impact analysis.

- CMS assumes that since 21 percent of current MA ESRD beneficiaries are enrolled in group plans, 21 percent of beneficiaries that migrate from Original Medicare to MA will elect to enroll in group plans. We believe that the vast majority of retirees with access to an EGWP plan are already enrolled in such plans, including those with ESRD. As a result, CMS should consider revising its assumption to reflect that a substantial minority of Original Medicare to MA ESRD migrants will choose group plans, because beneficiaries with access to group plans are likely already enrolled in them.

- CMS should consider producing a range of financial impacts based on the size of the possible migration population. With the aligned incentives of ESRD-Dialysis beneficiaries

and dialysis providers, we believe the size of the migration in 2021 could be substantially higher than CMS' projection, consistent with other published reports.[17]

- In summary, we believe that if CMS were to take into account the items above, the resulting potential impact to plan margins would be much greater than the -$0.23 PMPM quoted in the 2/20/2020 Actuarial User Group Call.

Because of the substantial uncertainty as to the size and composition of the migration of Original Medicare ESRD beneficiaries into MA plans in 2021, we are proposing that CMS set up a two-year (2021 and 2022 only) risk corridor program for MA ESRD experience. The structure of this program would be left up to CMS' discretion, but we have included an example below based on CMS' estimated 94 percent Medical Loss Ratio:

- If an MA plan's 2021 ESRD MLR is between 91 percent and 97 percent, no risk corridor payments will be made.
- If an MA plan's 2021 ESRD MLR is between 88-91 percent, the MA plan will pay 33 percent of the difference from a 91 percent MLR to CMS in risk corridor payments.
- If an MA plan's 2021 ESRD MLR is below 88 percent, the MA plan will additionally pay 66 percent of the difference from an 88 percent MLR to CMS in risk corridor payments.
- If an MA plan's 2021 ESRD MLR is between 97 percent and 100 percent, CMS will pay the MA plan 33 percent of the difference from a 97 percent MLR in risk corridor payments.
- If an MA plan's 2021 ESRD MLR is over 100 percent, CMS would additionally pay the MA plan 66 percent of the difference from a 100 percent MLR in risk corridor payments.

We are suggesting that this be a two-year program only, as the uncertainty in size and composition of the migrating Original Medicare ESRD population will dissipate as plans receive membership and claims experience data throughout 2021 and are able to develop programs to manage the new ESRD population. Emerging experience in CY2021, at the time that CY2022 bids are filed, will be insufficiently complete to establish an estimated MLR to price CY2022 bids appropriately. A two-year program is necessary to allow a full financial picture to emerge. Additionally, a risk corridor program set up in this way reduces uncertainty and provides the protection and flexibility needed by MAOs to maintain benefit levels to the overall MA population in 2021 and 2022 consistent with prior years.

[17] Bank of American Global Research, "Quantifying the advantage to Dialysis from the shift to MA, raising DVA ests/PO," January 17, 2020; Goldman Sachs Equity Research, "2021 dialysis mosaic comes to light; DVA to Buy," January 23, 2020.

V. Enhancements to the Part C and D Programs

Overall Comments on Stars Proposals

CMS proposes a wide array of changes and modifications to the existing Stars Rating program.

> **Humana comments:** Humana supports and appreciates CMS's ongoing efforts to improve the Star Rating program. However, the full set of changes being proposed represents a major overhaul of the program that will significantly and negatively disrupt contract Star Ratings. If the proposed changes were applied to the latest Star Ratings, many contracts would see a change to their Star Rating even though the underlying quality of the contracts has not changed. The continuity of the Star Ratings is critical to maintaining beneficiary trust in the program, stability of supplemental benefit offerings, and the ability of plans to continue to focus on quality improvement. We offer detailed comments on the proposals below, but we believe the aggregate impacts of these changes will be significantly greater than any of them in isolation. **Changes to the program of this magnitude should be incorporated slowly over time and not in unison.**
>
> In the two months since the Proposed Rule was released, the world has fundamentally changed. We are now facing a nearly unprecedented public health crisis that is placing extraordinary strain on our entire health care system. **Given the significant uncertainties around the COVID-19 crisis and its impact on the health care system, we encourage CMS to refrain from making major, systemic changes to the Stars Rating program at this time.**

Measure-level Star Ratings:

CMS is proposing to add Tukey outer fence outlier deletion to the clustering methodology for non-CAHPS measures. Additionally, CMS requests commenter feedback on Tukey outer fence outlier deletion as an additional step prior to hierarchal clustering.

> **Humana comments: Humana strongly opposes the outlier deletion methodology proposed by CMS.** We believe the proposal does not align with the spirit of the Star Rating program as it adjusts the methodology in such a way that it fails to represent quality and performance across all participating plans and ultimately creates the perception that high performing plans are providing lower quality care through the deletion of outliers. **We believe this approach is flawed and its financial impact to the MA program is understated.**
>
> However, Humana appreciates CMS's efforts to improve the stability and predictability of the measure cut-points and we continue to support the following methods, previously submitted in response to CMS-4185-P, to improve the cut point methodology:
>
> - **Full or partial advance notice of cut-points** - We further recommend CMS move to full or partial advance notice of cut-points. Having advance knowledge of the gold standard level of a measure will allow plans to better engage the right members, at the right time, for the right measures in order to maximize positive health outcomes. Having a known gold standard will also allow health plans to work with providers to establish stable and transparent multi-year quality improvement programs.
> - **Use of a restricted range cap instead of a straight percentage-point guardrail for all measures**. We note that even 0-100 measures may use only a portion of that

range. As an example, although Plan All-Cause Readmission (PCR) is technically a 0-100 measure, the range of results for Star Rating Year 2019 was three percent to 17 percent.

- **Use of continuous, rather than discrete, Star Ratings to increase stability, encourage continuous improvement, and more accurately reflect true performance differences between contracts.** We propose CMS consider a continuous measure Star model allowing measure Star Ratings to take on any value between one and five, not just integral values. This would inherently reward continuous improvement in measure rates and distinguish contract performance more clearly. We also propose CMS consider a continuous contract Star Rating model allowing contract Star Ratings to take on any value between one and five. This would again reduce the risk of contract misclassification since nearly-identical contracts would receive nearly-identical Star Ratings. Under the current methodology, the approach for rounding contract Star Ratings can magnify small variations in performance (e.g., contracts with unrounded ratings of 3.74 and 3.75 are rounded into final Star ratings of 3.5 and 4.0, respectively).

In reviewing CMS' proposal on the addition of a Tukey outer fence outlier deletion Humana believes CMS has significantly understated the impact of the proposal. As part of the proposed rule CMS states, "if the Tukey outlier deletion step and a 5% guardrail had been applied to the 2018 Star Ratings, 16% of contracts would have seen their rating decrease by half a star." While this may appear to be a minor shift in the ratings, the impact is substantial. Although CMS did not specify which contracts saw a Star Rating decrease in their analysis, if 16 percent of contracts for Star Rating Year 2020 had such a decrease, up to 15 million members could be impacted. **This is a very significant shift in Star Ratings.**

Additionally, an attached analysis by Wakely found that CMS significantly underestimated the adverse impact of this proposal on Star Ratings for plans.[18] Wakely estimates that applying the Tukey outlier methodology in the calculation of cut points for 2023 Star Ratings would reduce MA spending by $1.4 billion. This would cut MA plan payments in just the first year by nearly twice as much as CMS estimated. Nearly one-quarter of MA contracts would have their performance reduced by 0.5 Stars as a result of the methodology change.

We also believe that application of the Tukey outlier methodology in the Star Ratings program is potentially flawed. The Tukey outlier methodology is based on the assumption of a normal distribution of the underlying data[19]; however, many measures in the Star Ratings program have distributions with non-normal distributions, for example because they are significantly skewed in one direction.

Humana believes industry performance should be fully represented by including high and low performing outliers. Outlier contracts represent real performance – and real beneficiary experiences and health outcomes – by health plans that are outperforming or under-performing the industry. Removing them from the cut-point calculation would artificially distort the cut-

[18] Wakely Consulting Group. Proposed Rule Changes to the Medicare Star Rating Program: Analyzing the Impact of Proposed Changes on Medicare Advantage Spending. March 2020.
[19] Hubert, Mia, and Ellen Vandervieren. An adjusted boxplot for skewed distributions. Computational statistics & data analysis 52.12 (2008): 5186-5201.

points and fail to reward health plans who have higher than average performance in the program. For example, removing underperforming contracts makes cut-points more challenging, penalizing plans that have invested in performance improvements and limiting the number of opportunities those plans will have to reinvest bonus-dollars to enhance quality programs to promote improved beneficiary outcomes.

Contract Consolidations:

CMS proposes the following changes to contract consolidations occurring on or after January 1, 2021:

- Add a rule to account for instances when the measure score is missing from the consumed or surviving contract(s) due to a data integrity issue.
- Assign a score of zero for the missing measure score in the calculation of the enrollment-weighted measure score.
- The Timeliness Monitoring Project (TMP) or audit data will be combined for the consumed and surviving contracts.

Humana comments: Humana supports CMS' proposals to account for data integrity issues and TMP or audit data for consolidating contracts.

Rheumatoid Arthritis:

CMS proposes to remove the measure from the Star Ratings program for the 2023 Star Ratings.

Humana comments: Humana supports the retirement of the Rheumatoid Arthritis Health care Effectiveness Data and Information Set (HEDIS) measure for the reasons defined by the NCQA.

Updates to the Improving or Maintaining Physical Health Measure and Improving or Maintaining Mental Health Measure from the Health Outcomes Survey (HOS):

CMS is proposing the following changes to the measures:

- Modify the current approach for adjusting for differences in the case-mix of enrollees across contracts; and
- Increase the minimum required denominator from 30 to 100 for the two measures.

Humana comments: Humana supports the methodology changes and believes the proposed modifications will help ensure fair and comparable contract level scores with consistently reliable rates for the two measures. Given the substantive nature of this proposed change Humana urges CMS to clarify, through the final rule, these measures will be moved to display for measure years 2021 and 2022 (2023 and 2024 Star Ratings). CMS also should clarify the measures, upon returning to the Star Rating programs for measure year 2023, shall have a weight of one for the first year (measure year 2023 and 25 Star Ratings) and a weight of three for measure year 2024 (2026 Star Ratings) and beyond.

Statin Use in Persons with Diabetes (SUPD):

CMS proposes to modify the classification of the SUPD measure category from an intermediate outcome classification to be a process measure, starting with the 2023 Star Ratings.

Humana comments: For the purposes of the proposed rule, Humana supports CMS's proposal to categorize SUPD as a process measure. Given the nature of the requirements, we believe

this is the most effective and fair way to assess plan performance and optimize beneficiary health outcomes.

CMS indicates, in the 2021 Advance Notice, SUPD will move from a one weighted measure for the 2020 Star Ratings to a three weighted measure for the 2021 Star Ratings. We are concerned that this change, without notice, seems to be at odds with the spirit and intent of the agency's rules about making program changes without prior notice.

The 2020 Final Call Letter stated, "we will keep this measure's [SUPD] weight at one as a new measure while we further review this measure's category and consider if CMS should propose to change the technical specifications to reclassify it in the future." Organizations expected, once a decision was finalized, CMS would formally notify them of the decision to change the weight of the measure. Instead, the weight was changed in the Improvements Chart, within the 2021 Advance Notice, and formal notice was not provided.

Secondly, CMS proposed through 4190-P to reclassify the SUPD measure starting in 2023 to a process measure with a weight of one. Thus, SUPD will move from a weight of one in the 2020 Star Ratings, to a weight of three in 2021 and 2022 Star Ratings, and then back to a weight of one for the 2023 Star Ratings.

Humana strongly opposes the update to the weight of the SUPD measure for the 2021 and 2022 Star Ratings. As codified, "New measures to the Star Ratings program will receive a weight of 1 for their first year in the Star Ratings program. In subsequent years, the measure will be assigned the weight associated with its category." CMS, through the 2020 Final Call Letter, exercised their ability to continue measure weightings as "new", beyond the initial year the measure is in the Stars program, when the weighting of SUPD was continued as one weighted. As previously indicated, Humana agrees SUPD is a process measure and should receive the associated categorized weight of 1. Therefore, to avoid industry confusion, Humana strongly encourages CMS to not move forward with SUPD's weight change for the 2021 and 2022 Star Ratings and instead continue to apply a measure weight of one, as a new measure, until the proposed measure re-categorization is finalized and implemented.

Transitions of Care:

CMS is proposing to add the Transitions of Care measure to the 2023 Star Ratings, covering the contract year 2021 Performance Period, with the following changes:

- Broaden the forms of communications from one outpatient medical record to other forms of communication such as admission, discharge, and transfer record feeds, health information exchanges, and shared electronic medical records
- Change the notifications and receipts from "on the day of admission or discharge or the following day" to "on the day of admission or discharge or within the following two calendar days"
- Change one of the six criteria of the Receipt of Discharge Information indicator from "instructions to the primary care providers or ongoing care provider for patient care" to "instructions for patient care post-discharge"

Humana comments: While Humana supports the intent of the Transitions of Care measure, **we recommend CMS only include the two administrative components (Patient Engagement and Medication Reconciliation Post-Discharge) in Star Ratings for 2023. We further recommend**

keeping the hybrid components (Notification of Inpatient Admission and Receipt of Discharge Information) on display.

We recommend all four sub-measures for Transition of Care measures be reported separately and not as hybrid measures. In an effort to understand the patient experience, Humana has conducted Continuity of Care studies and has found there are lower rates of compliance with the hybrid measures like Notification of Inpatient Admission and Receipt of Discharge. This is largely due to operational barriers between providers, such as: lack of consistent electronic health record connectivity; facilities not consistently communicating admission and discharge information to the PCP; PCPs not being part of the facility network, facilities not having established processes to provide notifications; lack of consistent documentation practices among PCPs; and failure for PCPs to provide medical charts for review. Additionally, analysis of 2018 display results showed the industry reported a 16 percent average compliance rate for Notification of Inpatient Admission and a 10 percent average compliance rate for Receipt of Discharge Information. However, compliance with Patient Engagement was 81 percent, implying the two hybrid components may not be indicative of the true performance for coordination of care and follow-up activities.

Further, **Humana recommends the hybrid sub-measures for Notification of Inpatient Admission and Receipt of Discharge Information remain on Display while industry standards are developed to support consistent and accurate reporting of the measures**. We recommend focus be placed on the remaining two administrative sub-measures, Patient Engagement After Inpatient Discharge and Medication Reconciliation Post-Discharge, and both enter the Stars program as independent measures. This approach would be similar to historical Stars program decisions to treat Comprehensive Diabetes Care sub-measures and Care for Older Adult sub-measures independently, while still ensuring appropriate visibility and quality improvement efforts to advance the quality of member care.

Additionally, **Humana supports the inclusion of the Transitions of Care: Medication Reconciliation Post-Discharge sub-measure as a replacement to the current Medication Reconciliation Post-Discharge measure being proposed for retirement.**

Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions:
CMS is proposing to add a new HEDIS measure assessing follow-up care provided after an emergency department (ED) visit for patients with multiple chronic conditions. The proposal is to add this measure to the 2023 Star Ratings covering the contract year 2021 measurement period.

Humana comments: While Humana appreciates the intent of the measure to assess follow-up care provided after an ED visit for beneficiaries with multiple chronic conditions, we do not believe health plans will have timely receipt of claims data to allow them to influence the measure.

Humana completed an analysis of a full-month sample of emergency department (ED) claims from the 2019 measurement year to determine potential challenges with complying with the proposed measure. In our analysis, **less than 46 percent of claims were received within seven days of the ED visit, and less than nine percent of the claims were received in the first four days.** Ultimately, this indicates fewer than half of claims will reach a health plan before follow-up is required. Given this lag in claims submission by hospital emergency departments, health

plans are not likely to receive the information on an emergency room visit for patients with multiple chronic conditions in a timely manner to ensure patients receive a follow-up with their Primary Care Physician (PCP) within seven days.

Furthermore, the identification of an "inbound" admission for the purposes of this measure is also challenging. This process requires the claim to be adjudicated through a clinical rules engine to determine which conditions are considered "inbounds" for the defined chronic conditions, taking most claims beyond the seven-day requirement. In fact, the average time for a claim to get to us is twelve days with a median timeframe of eight days.

Further, research suggests the **availability of PCP appointments within seven days of an emergency room discharge can be limited**. According to a study published in the Annals of Emergency Medicine and presented by the American College of Physicians Scientific Assembly Research Forum focused on insurance follow-up after an emergency room visit based on 604 calls, covering three types of insurance (Medicaid, commercial, and state exchange), a follow-up appointment within seven days was only available 30.7 percent of the time.[20] Therefore, even if all of the information between providers, hospital systems, and health plans moved seamlessly between the different care teams there would still be limited opportunities for the follow up to be completed within seven days.

The recently announced modification to conditions of Medicare participation requires hospitals (including ED visits), psychiatric hospitals and critical access hospitals, to send electronic notifications of a patient's admission, discharge and/or transfer (ADT) to another healthcare facility, to another community provider or practitioner. However, payers will not directly receive ADT information but will be held accountable for measure quality while continuing to be dependent on receiving appropriate notifications under the aforementioned timelines.

While Humana encourages beneficiaries to seek care in the most clinically effective settings, it is not uncommon for a beneficiary with multiple chronic conditions to seek care in the emergency department for reasons other than their chronic conditions (e.g. falls or urinary tract infections). Humana supports members through the following:

- Care management services
- Enhanced or specialized engagement for our higher acuity members
- Condition specific education
- Appropriate follow-up based on condition and symptoms

Additionally, Humana provides information through our website, and via customer care, to guide members on appropriate usage of the emergency department. Provided information includes suggestions for alternative places of treatment to receive care.

Overall, Humana supports the intent of the measure but believes the data sharing challenges are too significant at this point in time for CMS to adopt this HEDIS measure for Star Rating purposes.

[20] Miller, G. (2017), Treating patients seeking primary care after emergency room visits. Retrieved from https://www.elationhealth.com/primary-care-physicians-blog/after-er/

Patient Experience and Access Measures:

CMS is proposing to increase the weight of Patient Experience/Complaints and Access measures to a weight of 4 to place a greater emphasis on patient experience/complaints and access to care issues.

Humana comments: Humana supports CMS's efforts to emphasize the importance of the member experience, however **we do not believe Patient Experience/Complaints and Access measures should carry a greater weight than measures of health outcomes.** CMS has already taken steps to increase the weight of member experience measures, moving from a weight of 1.5 to a weight of 2 in 2021 Star Ratings. We do not support further increases in the weighting of these measures as it would have the unintended consequence of devaluing health outcome related measures.

The Star Ratings program was created to "optimiz[e] health outcomes by improving quality and transforming the health care system" through targeted measures to incent plan performance.[21] In developing the program, CMS sought to create measures to assess the quality of health and drug services received by beneficiaries and the experience of those beneficiaries enrolled in MA-PD plans.

With the proposed change, Patient Experience/Complaints and Access measures would account for 56 percent of the overall Star Rating, compared to 17 percent for Intermediate Outcomes and Outcome measures. As a result, the proposal would disproportionately skew the balance towards member experience and how beneficiaries feel about their health plan versus beneficiaries' health outcomes. We fear the proposed weighting changes improperly emphasize the member experience over the quality of care delivered and ultimately could reduce plan focus on improving member health outcomes. The improvement of member health outcomes is one of the largest drivers of the long-term goal to reduce American health care costs. To better reflect the stated program goals these measures should carry a more equal overall weight to the Stars program. **As stated, Humana believes the member experience is a significant and important component to their health care quality and supports CMS driving member experience as a priority across the industry. However, we do not believe this solution is an overall improvement to the Stars program.**

We also have significant concerns regarding the volatility of Patient Experience/Complaints and Access measures. As detailed in a report prepared by Wakely (attached), there is significant year-over-year volatility in average Star Ratings for Patient Experience/Complaints and Access measures, despite consistent trends in plan performance over time. This volatility is primarily driven by the cut point methodology, and results in a weak correlation between plan performance and Star Ratings for these measures. **As the intended purpose of the Star Ratings program is to compare plan performance on measures related to beneficiary health outcomes and experience, increasing the weights for these measures will further erode the integrity of the Star Ratings program by basing the majority of the Star Rating score on measures with little correlation to plan performance.**

Beyond this specific proposal, **Humana continues to urge the agency to consider implementing changes in the Star Ratings program incrementally**. As previously discussed, the structure of

[21] https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Star-Ratings-Technical-Notes-Oct-10-2019.pdf

the program dictates the opportunities for beneficiaries to receive additional benefits~~,~~ and guides the allocation of plan and provider resources. When CMS implements multiple large scale changes at one time, the implications and impacts on each of these stakeholders can be significant and without warning. For example, the proposed change on the weight of Patient Experience/Complaints and Access measures could impact a total of 14 measures at one time and have significant implications for plan performance and payment, which could ultimately lead to reductions in MA plan supplemental benefits. In addition to the proposal for Patient Experience/Complaints and Access measures, there are eight additional measures with substantial changes – resulting in **over half of the measures in the program having substantive measure or weighting changes for the 2023 Star Ratings.** Lastly, CMS's proposal to change the threshold calculation logic will also impact measures. **Humana recommends CMS: 1) avoid making such drastic changes to the program all at one time; 2) address the lack of a strong relationship between performance and contract level Star ratings caused by the cut-point methodology; and 3) focus on outcomes measures.**

Furthermore, Humana believes there are inconsistencies and opportunities for improvement with existing Patient Experience/Complaints and Access measures. We believe these issues are further evidence for leaving the measures at their current weighting. Regardless of a final decision to move forward on weighting changes, Humana requests CMS review methodology changes for the measures below to ensure accurate accounting of quality as it relates to the plans.

- **CAHPS Member Perspective:** Humana recommends that CMS allow a third-party to validate all survey data (CAHPS and HOS) to ensure reported results are representative and accurate. The third-party review could include review of sample draws as well as results calculations. CMS has identified errors in the past, impacting reported results, after survey administration was completed. Errors of 0.1 percent on a measure can result in a plan not achieving the appropriate Star level, resulting in significant impacts to the plan and the enrollees.

- **Members Choosing to Leave Plan:** Humana recognizes the value of measuring and reporting the disenrollment metric, but believes the measure is flawed and misrepresents some changes in enrollment as an expression of dissatisfaction. For example, we recommend CMS consider excluding members who switch plans but stay with the same parent organization, as it may actually suggest a high level of satisfaction with the parent organization. Today, the measure assumes the beneficiary is dissatisfied with the parent organization's performance, when the change of enrollment may have actually been driven by the beneficiary's preference of one plan benefit design over another.

- **Complaints:** Humana also appreciates the need to evaluate plan performance based on the complaints received from beneficiaries. However, there are some beneficiary complaints, resulting from CMS policy decisions, we believe should be excluded when evaluating plan performance. Several examples of these policies include:

  - **LIS Plan Changes**: The recent policy change limiting LIS members to one plan change per quarter has significantly increased the volume of complaints. When members complain to CMS, they can receive a Special Election (SEP) to change plans. The

unintended consequence of increased complaints due to the CMS policy change is therefore impacting perceived plan performance. Humana encourages CMS to consider excluding complaints from LIS beneficiaries resulting in plan changes from this measure.

- **Late Enrollment Penalty:** Since the inception of the Part D program, CMS has imposed a late enrollment penalty on beneficiaries who delay enrollment in the Part D program. However, beneficiaries who receive the late enrollment penalty occasionally file a complaint against the plan sponsor – who is simply meeting the requirements of the program defined by CMS when a late enrollment penalty is assessed. Therefore, we recommend CMS add complaints related to the late enrollment penalty to the Exclusion list for Complaints as it relates to plan performance.
- **Provider Complaints:** Provider complaints are also currently included but the measure is calculated on a per 1,000 member basis. This approach results in a skew in the data due to inclusion of providers who already have other pathways within plans to manage provider correspondence.
- **2017 CMS Process Changes:** CMS initiated operational process changes in 2017 that limited the amount of information provided to health plans on the complaints CMS received. In these cases it can be difficult to identify root cause of the member complaint, resulting in barriers to remediation efforts. Humana proposes CMS revert to historical practice of including exclusion criteria and more detail in the complaint log.
- **TTY/FL**: With regard to Part C and Part D Call Center Monitoring Accuracy & Accessibility Studies, Humana requests CMS consider publishing these results in HPMS on the same frequency as the Part C and Part D Timeliness Study (quarterly). This would allow plan sponsors to better align internal testing/monitoring against CMS third party testing, assisting efforts to continuously improve these services. Should deficiencies be found by a third party, instead of through internal testing, this would further support more efficient identification and correction of process issues affecting enrollee and prospective enrollee services.

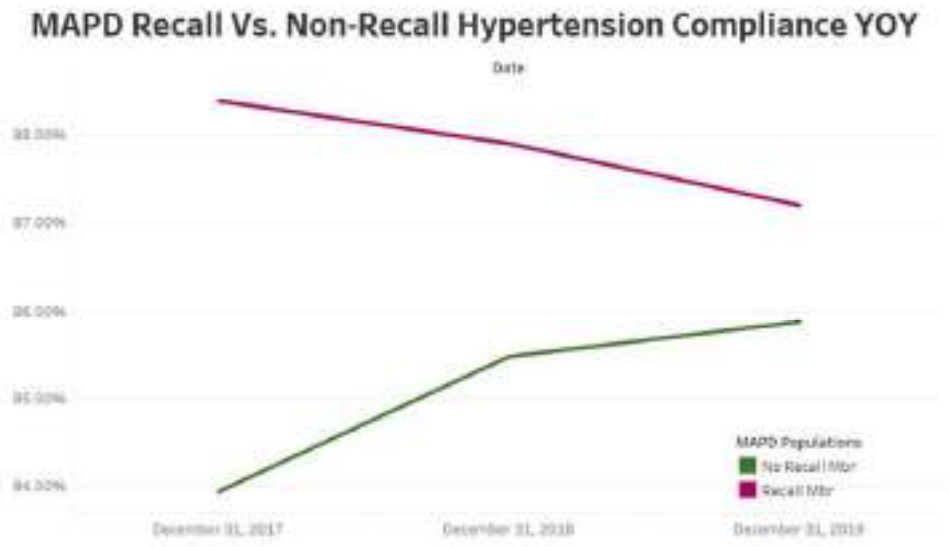
Extreme and Uncontrollable Circumstances (Multi-Year Impacts):

CMS is soliciting additional feedback on the disaster policy for contracts impacted across multiple years

Humana comments: Humana supports CMS' efforts to account for extreme and uncontrollable circumstances ("disasters") impacting contract quality and/or measurement. **In light of the COVID-19 crisis, we propose CMS expand the current rule for contracts impacted by two different disasters in consecutive years to include contracts impacted by a single disaster spanning multiple years.** This will allow the policy to account for disasters and public health emergencies that have long lasting effects or occur at the end of a coverage year. For example, instances in which a disaster occurs late in the coverage year will not have the true impact felt until the following coverage year. There are also instances in which a public health emergency is declared the year after the event occurred. This was true in the case of Hurricane Maria, in Puerto Rico. The impacts of Hurricane Maria were felt deep into 2018, to the extent that as late as April 2018 a public health emergency was declared related to the hurricane. However the current structure of the extreme and uncontrollable policy did not allow the disaster relief from Hurricane Maria to apply to Puerto Rico contracts in 2018.

The current policy for contracts impacted by consecutive disasters guarantees the contract's measure Star Ratings will be based on a year impacted by a disaster. Therefore the policy does not actually provide relief to these contracts. **Given this, we recommend CMS expand the available options for replacing the measure rate and Star in those cases to include the best of the most recent year not impacted by a disaster, the parent organization average, or the industry average.** We believe these approaches, particularly the parent organization average, would address some of CMS' historical concerns on the applicability and timeliness of the data used for Star Ratings.

While the policy for extreme and uncontrollable conditions has traditionally been focused on natural disasters, we recommend CMS consider expanding the policy to capture other uncontrollable circumstances. Two areas of concern, especially in the wake of COVID-19, is prescription drug shortages and prescription drug recalls. While plans are implementing best effort strategies to help beneficiaries maintain access to their medications, shortages that result from this emergency shortage or supply disruption for a specific medication should be taken into account under the extreme and uncontrollable circumstance rule. With regard to recalls, in 2018 and 2019, there were an unprecedented number of recalls for angiotensin-II receptor blockers (ARB) – amounting to the largest recall in a single pharmaceutical class's history. Since mid-2018, there have been twenty-eight ARB recalls impacting Humana's membership with fifteen of those occurring in 2019 alone. These recalls impacted over 1.4 million prescriptions for our Medicare members. Despite Humana's contingency efforts, which include identification and outreach to potentially impacted members to provide early refills and/or early supplies of significant or life-threatening medication, these recalls had an adverse impact on hypertension adherence. Upon examining the population impacted by the recalls compared to those not impacted, a decline of performance was seen year-over-year for beneficiaries who were impacted by an ARB recall between 2017 and 2019.



It is also important to acknowledge the recall itself has ripple effects such as negative media reports and adverse reactions from medication switching which could further exacerbate the impact of the recall. In totality, the recalls and the associated externalities with them caused a substantial impact to overall hypertension adherence performance and improvement. Given this

data and the magnitude of recalls, we propose CMS evaluate the inclusion of other factors in utilization of the extreme and uncontrollable policy, particularly for the 2021 Star Ratings and Medication Adherence for the Hypertension Medications measure.

While each such disruption can be unique in its impacts, we suggest CMS consider how such issues affect individual measures and when measure impact is significant, take action with Star Rating calculations. A suggested method for determining the impact on individual contracts for drug recalls specifically is detailed below. We propose two hold harmless provisions be added to the Star Rating calculation methodology in these circumstances. **First, we propose impacted measures be given a hold harmless provision within the Improvement Measure calculation (i.e. leaving the measure in if it does not negatively impact the improvement measure calculation but taking it out if it does). Second, we propose a hold harmless provision be granted for the measure rating itself, awarding whichever measure Star Rating is higher, the rating for the impacted year or the prior year.**

Humana recommends CMS use a multi-year analysis to determine the impact of medication recalls and/or drug shortages on performance results. We propose CMS utilize the Prescription Drug Event data to determine members who qualify for the applicable Stars measure and then develop two population subsets: qualifying enrollees who are impacted by the medication challenges and those enrollees without an impacted claim. Utilizing this information, we would recommend the adherence performance for these two subsets be tracked year over year to determine if members impacted by the recalled medications have a negative performance impact compared to non-recalled members. If there is any decline in performance, then we propose CMS apply the two hold harmless provisions detailed above.

Additionally, we note other types of significant disruptions can have similar impacts to individual measure performance. For example, the current coronavirus epidemic has disrupted pharmaceutical and medical device manufacturing facilities in China and throughout the world. If the drug supply chain is negatively impacted, patients may have difficulty accessing affected products, which would drive down medication adherence rates despite the best efforts of the plan.

MA and Part D Prescription Drug Program Quality Rating System

CMS explains they are making routine changes to the program and notes these types of changes have historically had negligible impacts to the highest ratings.

Humana comments: Humana appreciates CMS sharing the results of their internal modeling for the Medicare Trust Fund impacts of the proposed changes to the Patient Experience and Access measure weights and the addition of the Tukey outer fence outlier deletion step to the cut point calculations as part of the Economic Impact Analysis.

However, we request additional information on this modeling and the potential longitudinal impacts that it could have on the program. We encourage CMS to be transparent in their methodology to ensure that all industry stakeholders have the opportunity to comment on the potential impacts.

1. It appears, based on Table 30, the net savings before inflation ($417.5M) is calculated by subtracting the Patient Experience and Access measure weight cost ($391.4M) from the Tukey outlier deletion savings ($808.9M). Can CMS please clarify whether the net savings

was calculated using Star Ratings, inclusive of both changes, or was the cost of Patient Experience and Access weight changes and the savings from Tukey outlier deletion calculated separately and the results netted together? If the latter, we request CMS re-run the model calculation based on recalculated Star Ratings inclusive of both changes. Humana's internal analysis suggests applying the two changes in concert may give very different results from applying each one separately and then adding the results.

2. The language in section E-3, summarizing the contract-level Star Rating impacts of the Tukey outlier deletion step, states the analysis was done using Star Rating Year 2018.
   (a) Were the cost and savings in Table 30 calculated based on Star Rating Year 2018 as well?
   (b) We request CMS also re-run the calculation of both contract-level impacts and cost/savings using Star Rating Years 2019 and 2020 as the starting point. In particular we have observed the measure cut-points for different Star Rating years are not always impacted by outliers in the same way, and therefore using different Star Rating years as the baseline for the cost or savings model may give very different results.

3) Finally, we request CMS provide the detailed results of the Star Rating recalculations they performed including the proposed changes, including:
   (a) The recalculated cut-points by measure
   (b) The recalculated measure Stars by contract
   (c) The recalculated contract Stars including the usual details
   (d) The recalculated r-factor mean and variance thresholds
   (e) Any recalculations of other model parameters or outputs normally reported in the public Stars results on the Part C and D performance page

Additional Stars Rating Issues Not Included in the Proposed Rule:

Humana appreciates the opportunity to provide feedback for topics not contained within the proposed rule. Further, we appreciate the opportunity to propose changes that will continue to improve plan quality for members, enable providers to deliver coordinated care to their patients, and drive efficiencies in a costly, disconnected system.

Humana comments:

Significant Digits

We recommend CMS undertake a study to review how measure thresholds would change when measure rate rounding rules are expanded to include an additional significant digit. While we support some degree of measure rate rounding for the determination and application of thresholds to produce a measure's Star Rating, where there is a tight distribution of performance the current rounding rules may create a barrier to recognizing performance variation. For instance, the Plan All-Cause Readmissions measure has a small spread with all publicly reported rates for Star Ratings 2020 falling between zero percent and 14 percent. Two hypothetical contracts (which may exist in the raw unpublished data) could have achieved rates of 6.4 percent and 6.5 percent which, due to current rounding rules, would have achieved dissimilar measure Star Ratings for a very minor rate variation. It is theoretically possible a cluster analysis of this measure, using slightly different rounding rules for measure rate inputs, could have produced different measure clusters that would have grouped these plans together. If CMS is willing to undertake this analysis, it may find evidence to support rounding

adjustments to specific measures that could ultimately refine the broader Stars program and improve the identification of performance.

Availability of Methodology Factors

In Humana's response to the proposed changes to measure Star calculations, we noted we support advance notice of measure cut points. **We further propose CMS calculate and release in advance the other key parameters of the Star Rating model** – for example, the CAI decile buckets and adjustments, the r-factor mean and variance thresholds, and any other model parameters necessary to calculate a contract Star Rating. We propose CMS publish all of these values in advance of the HEDIS measurement year corresponding to the Star Rating year – for example, in advance of 2020 for 2022 Star Ratings. This would allow plans to better coordinate their quality improvement efforts with providers, deliver better performance projections, plan for future benefit changes, better prioritize our quality improvement efforts to be as efficient as possible, and generally simplify and add transparency to the Star Ratings program.

Extension of Display Period

Humana appreciates CMS placing measures on display for a minimum of two years before moving to Stars, however **we recommend CMS leave a measure on display for a minimum of three years to allow sufficient time for CMS and plans to review results before it is decided to move a measure into the Stars program.** The current two-year cycle requires CMS to finalize decisions to move a measure from display to Stars before the first year of display performance is available. For example, prior to a display measure moving to 2023 Stars, CMS must state in the Final Rule for 4190-F a display measure will be added to the Stars program for 2021 measurement and 2023 Star Ratings, before CMS or plans have seen results from the first year the measure was on display. Additionally, several activities are integral to the management and performance improvement of measures and cannot reasonably be accomplished within the current limited time frame, such as provider education, changes to benefits, and industry analysis.

Consolidation of Measure Information

Humana appreciates CMS defining the Stars Rating program in advance of the measurement year, for example all changes to the 2023 Star Ratings (2021 measurement year) will be codified by the Final Rule in 2020. Humana also appreciates CMS summarizing the previous year's plan measurement in the Advance and Final Notice; as shown in Table 1 of the 2020 Advance Notice which confirms the list of measures, measure weightings, and inclusion in the Improvement measure for the 2019 Measurement year. This information provides clarity as well as a summary in one document. As noted above, **Humana requests CMS provide that same level of transparency for the measurement year that has already been defined and for the measurement year that has just been codified.** For example, Humana requests CMS include a similar table in the 2020 Final Notice, for both the 2021 and 2022 Star Ratings, and include a similar table in the 2020 Final Rule for the 2023 Star Ratings.

Below is a proposed example table containing the type of information Humana requests CMS release annually to show the three in-scope measurement years. The intent is for the industry to better understand which measures are in-scope and each measure weighting and Improvement measure weighting. This transparency will allow plans and the industry to better track CMS's intent and avoid confusion, such as the confusion seen with the SUPD weighting for 2021 Star Ratings.

Measure	2021 Star Ratings		2022 Star Ratings		2023 Star Ratings	
	Measure Weight	Improvement Weight	Measure Weight	Improvement Weight	Measure Weight	Improvement Weight
Medicare Plan Finder Accuracy	1	1	1	NA - New	1	1
Controlling Blood Pressure	Display	Display	1	NA - New	3	1
Adult BMI Assessment	1	1				
Improving or Maintaining Physical Health	3	NA	3	NA	Display	Display
Care Coordination	2	1.5	2	2	4	2

Note: Grid includes examples of measures and not the full measure list. NA = Not Applicable.

Page Numbers

Lastly, **Humana requests CMS include page numbers on their Stars Rating documents to facilitate discussion and utilization across the industry.**

Permitting a Second, "Preferred", Specialty Tier in Part D (§§ 423.104, 423.560, and 423.578)

CMS proposes new Part D sponsor flexibility in formulary design with the option to offer a second, "preferred" specialty drug tier. The proposal continues to allow plans to prohibit tiering exceptions for specialty tier drugs to a cost-sharing level that applies to a non-specialty tier , however proposes to require Part D sponsors to permit tiering exception requests for drugs on the higher cost-sharing specialty tier to the lower cost-sharing specialty tier. Maximum allowable cost sharing is proposed for the specialty tiers of between 25 percent and 33 percent, depending on whether the plan includes a deductible and the cost-sharing differential for the preferred specialty tier must be less than the highest specialty drug tier. Finally, CMS proposes to determine the annual specialty-tier cost threshold for both specialty tiers based on the top 1 percent of 30-day equivalent supplies of the ingredient cost reported on PDE data for the plan year that ended 12 months before the applicable plan year. CMS is proposing to increase the specialty-tier cost threshold to $780 (as a 30-day equivalent *ingredient cost*) for contract year 2021 from the previous $670 (as a 30-day equivalent *negotiated price*).

Humana comments: As the Medicare Payment Advisory Commission (MedPAC) has previously noted, a two-tiered Part D specialty drug formulary could increase competition between specialty drugs with therapeutic substitutes and encourage the use of lower cost biosimilar drugs—once more biosimilars gain FDA approval. Humana supports CMS providing this additional formulary flexibility that could allow plans to leverage competitive forces to lower the costs on high priced specialty drugs. In the absence of increasing the maximum allowable cost sharing on the highest specialty drug tier and prohibiting tiering exceptions between specialty drug tiers, we share CMS concerns that this proposal may not materially affect Part D specialty drug costs. Finally, we agree with CMS' proposed annual specialty-tier cost threshold methodology, which would account for rising drug costs as well as potential changes in utilization**.**

Beneficiary Real Time Benefit Tool (RTBT) (§§ 423.128)

CMS proposes to require Part D sponsors to implement a beneficiary RTBT that would allow enrollees to view accurate, timely, and clinically appropriate patient-specific, real-time formulary and benefit information, effective January 1, 2022 (online or through a call center representative). Additionally, the agency proposes to allow plan sponsors to offer beneficiaries' health related rewards and incentives for the use of the RTBT.

Humana comments: **Humana applauds CMS' efforts to expand access to RTBTs to beneficiaries, providing member-specific, real-time cost and coverage information.** Humana is committed to effectively using technology to improve both the overall experience and transparency for both beneficiaries and prescribers. Humana was the first Part D plan to provide beneficiaries with real-time access to drug cost and provide formulary information to physicians and their patients through our RTBT IntelligentRx. IntelligentRx integrates within EMRs and pharmacy point-of-sale technology to provide real-time benefit information on drug coverage, formulary alternatives, pricing and pricing of drug alternatives and enables physicians and their patients to make joint treatment decisions based upon efficacy and cost. IntelligentRx is available to providers of all 10 million Humana members, including individuals with Medicare, Medicaid, and employer coverage.

Both research and recent initiatives, including American Patients First (Trump Administration's "Blue Print"[22]), have demonstrated beneficiaries' desire for more coverage transparency and involvement in their healthcare and treatment decision-making process. Humana supports CMS's efforts to improve transparency for beneficiaries and believes that extending RTBTs to beneficiaries by January 1, 2022 will create value and empowerment for our members. Humana's IntelligentRx has successfully demonstrated the value of a RTBT for beneficiaries in both price and alternative medication transparency. Humana research has found that when lower cost alternatives were displayed through IntelligentRx the prescription was changed 37 percent of the time. Other RTBT research also found that when a RTBT tool was utilized for prescriptions requiring a prior authorization (PA), and alternatives without PAs were available, the prescription was changed 28 percent of the time, saving both the provider and patient potential waiting time.[23] Additionally, given the strong correlation between lower-cost-alternatives and medication adherence, we are confident a beneficiary RTBT will have a positive impact on patient outcomes.[24,25]

Drugs to be Included in the RTBT

Humana comments: Humana appreciates the recommendation to allow individual plan P&T committees to evaluate whether certain medications should be excluded from the beneficiary RTBT tool. While Humana believes RTBTs should evaluate safety of every single medication, we appreciate allowing the plans to have flexibility on excluding certain medications in the beneficiary-facing RTBT based on clinical factors and recommendations of the individual plan's P&T Committee.

Differences in Provider and Beneficiary Facing RTBT

[22] Department of Health and Humana Services (HHS). American Patients First. 2018. Retrived from HHS Website: https://www.hhs.gov/sites/default/files/AmericanPatientsFirst.pdf.
[23] Surescripts Network Data. December 2018. Time Savings Analysis based on American Medical Association, "2017 AMA Prior Authorization Physician Survey".
[24] Eaddy MT, Cook CL, O'Day K, Burch SP, Cantrell CR. How patient cost-sharing trends affect adherence and outcomes: A literature review. P T. 2012;37 (1):45–55.
[25] Viswanathan M, Golin CE, Jones CD, et al. Interventions to improve adherence to self-administered medications for chronic diseases in the United States: A systematic review. Ann Intern Med. 2012

Humana comments: Humana is developing a beneficiary RTBT that will minimize the displayed information that would create extra data-burden on the patient, including unnecessary variables such as provider and pharmacy NPI. The tool will however display consumer-friendly data, such as information saved on the patient's preferred pharmacy and comparison pharmacies within network, patient's cost-sharing information, and formulary status of clinically appropriate formulary alternatives, including any UM requirements, step therapy, quantity limits, and prior authorization, applicable to each alternative medication.

Rewards and Incentives

CMS proposes to allow plans to offer rewards and incentives (R&I) to their enrollees who *use* the tool. CMS currently proposes defining "use" of the RTBT as: "logging onto either the portal or application or calling the plan's call center to ask for information, without regard to whether the enrollee engages in a discussion with his or her prescriber or obtains or switches to any medication in response to such use."

Humana comments: Humana supports the use of R&I as a tool for plan sponsors to encourage beneficiary behavior intended to improve health outcomes, enhance medication adherence, and help drive beneficiaries to lower cost therapeutic alternatives. CMS has proposed to allow plan sponsors to incent beneficiary behavior by using rewards and incentives to promote the use of a real time benefit tool (RTBT). While we support the use of R&I, we recommend shifting the purpose of a beneficiary utilizing a RTBT as opportunity to inform and engage the patient in decisions that affect their healthcare and provide them with cost-savings opportunities. We believe that plans should develop dashboards or a patient-specific landing page within the applications, or available upon engaging with call center, that allow the patient to track their out-of-pocket savings by utilizing the RTBT, including switching to lower-cost alternatives. We envision cost savings being displayed on the individual patient's dashboard.

Additionally, it is important to mention the slow process of integrating tools, such as a RTBT, into the large influx of EMR systems on the market today. However, even when a RTBT is not completely integrated into an EMR system, a patient would have the ability to present at a physician's office with their RTBT in hand with their saved prescription information in the dashboard. While concerns have been raised in the past, the case can no longer be made that this type of technological platform is not appropriate for Medicare population. Recent research has found that older adults are the fastest growing group in terms of smartphone ownership, with 74 percent of adults aged 55+ and 55 percent of adults 70+ now owning a smartphone.[26,27]

Validation of RTBT

Humana comments: Given that Humana has been at the forefront of development of a RTBT, we would gladly welcome an opportunity to collaborate with CMS on examining which data elements are important for display in a beneficiary-facing RTBT and helping advise on the

[26] Westcott K, Loucks J, et al. Built It and They Will Embrace it. Deloitte Insights. 2019 Retrieved from: https://www2.deloitte.com/content/dam/insights/us/articles/6457_Mobile-trends-survey/DI_Build-it-and-they-will-embrace-it.pdf

[27] Anderson G, Technology use and Attitudes Among Mid-Life and Older Americans. AARP Research. 2017. Retrieved from: https://www.aarp.org/research/topics/technology/info-2018/technology-use-attitudes.html.

development of operational plans for enforcing compliance and validation of both provider and beneficiary RTBT tools.

Medicare Advantage (MA) and Cost Plan Network Adequacy (§§ 417.416 and 422.116)

CMS proposes to make the following changes to existing MA network adequacy regulations and guidance:

- require that at least 85 percent of beneficiaries have access to at least one provider/facility of each specialty type within the published time and distance standards in non-urban counties;
- provide a 10 percentage point credit towards the percentage of beneficiaries residing within the applicable time and distance standards for certain provider specialty types when the plan contracts with telehealth providers for those specified specialty types; and
- provide a 10 percentage point credit towards the percentage of beneficiaries residing within the applicable time and distance standards for affected provider and facility types in states with certificate of need or other state imposed anti-competitive restrictions that limit the number of providers or facilities in a county or state.

Humana comments: We strongly support CMS's proposed changes to enhance network adequacy flexibility and urge the agency to finalize them as quickly as possible. We have included more detailed comments below.

85 Percent Standard for Non-Urban

We strongly support the 85 percent time and distance standard and urge CMS to consider reducing the standard further in subsequent rulemaking. Based on our review of 3,225 counties in CMS's most recent provider supply file, **MA plans cannot meet the existing 90 percent standard in 349 non-urban counties even if they include every area provider in their network.** Plans have no other choice than to file exception requests. **Revising the standard to 85 percent would more closely align the applicable standard with the actual supply of providers and reduce the number of network adequacy exception requests, which are administratively burdensome for MAOs and CMS.** On average, each exception request requires approximately 10 hours of Humana staff time to complete. Moving forward, we encourage CMS to collaborate with MAOs to improve the exceptions criteria and process to better reduce administrative burden and reflect the changing health care landscape.

Telehealth

We applaud CMS for taking aggressive action to expand Medicare coverage of telehealth services in response to the COVID-19 crisis. As a larger share of patient encounters begin to transition to telehealth, it will be critical for CMS to update existing network adequacy standards to reflect that new reality. We believe this crisis will ultimately serve as an inflection point in the adoption of telehealth and we applaud CMS' proposal. **We encourage CMS to expand the specialty types to include, at a minimum, allergy and immunology, psychiatry, nephrology, ophthalmology, cardiology, neurology, and primary care. We also believe that CMS should consider a broader reassessment of the established time and distance standards in future rulemaking in order to better reflect emerging technologies and evolving practices.**

Certificate of Need

We applaud the Trump Administration for recommending that states repeal certificate of need laws in order to improve market competition and lower prices.[28] The Federal Trade Commission and the Department of Justice have long argued that state certificate of need laws are costly, unnecessary barriers to entry for healthcare providers rather than tools for controlling costs or improving quality.[29] **We urge CMS to finalize its proposal to provide a 10 percent credit in states with certificate of need laws or other state imposed anti-competitive restrictions that limit the number of providers or facilities in a county or state.**

CMS seeks public comment on the following policy options to measure and set minimum standards for access to dialysis services:

- whether CMS should remove outpatient dialysis from the list of facility types for which MA plans need to meet time and distance standards;
- allowing plans to attest to providing medically necessary dialysis services in its contract application instead of requiring each MA plan to meet time and distance standards for providers of these services;
- allowing exceptions to time and distance standards if a plan is instead covering home dialysis for all enrollees who need these services; and
- customizing time and distance standards for all dialysis facilities.

Humana comments: The outpatient dialysis market is highly concentrated, with two companies currently controlling nearly 75 percent of dialysis services available to Medicare beneficiaries.[30] Recent research has found that, while overall beneficiary outcomes – as measured by hospital days and mortality – have improved over time, outcomes in independently owned facilities acquired by these two companies were negatively impacted after acquisition.[31] These results raise concerns about the role of consolidation in the dialysis industry.[32] Consolidation in the dialysis market has also led to significantly higher prices – for one large dialysis provider,

[28] See https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf

[29] See, e.g., Joint Statement of the Fed. Trade Comm'n and the Antitrust Div. of the U.S. Dep't Justice Regarding Certificate-of-Need (CON) Laws and Alaska Senate Bill 62, Which Would Repeal Alaska's CON Program (2017). https://www.ftc.gov/policy/advocacy/advocacy-filings/2017/04/joint-statement-federal-trade-commission-antitrustdivision. Accessed August 23, 2018; Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Carolina House Bill 3250 (2016). https://www.justice.gov/atr/file/812606/download. Accessed August 23, 2018. For selected FTC and Division comments regarding state CON laws from 2008 -2016, see Joint Statement of the Fed. Trade Comm'n and the Antitrust Div. of the U.S. Dep't Justice Regarding Certificate-of-Need (CON) Laws and Alaska Senate Bill 62, Which Would Repeal Alaska's CON Program (2017). https://www.ftc.gov/policy/advocacy/advocacy-filings/2017/04/joint-statementfederal-trade-commission-antitrust-division. Accessed August 23, 2018.

[30] Analysis of CMS Medicare Dialysis Facility Compare - Listing by Facility data. Last updated on January 22, 2020 and available at online: https://data.medicare.gov/Dialysis-Facility-Compare/Dialysis-Facility-Compare-Listing-by-Facility/23ew-n7w9

[31] Erickson KF, Zhao B, Niu J, et al. Association of Hospitalization and Mortality Among Patients Initiating Dialysis With Hemodialysis Facility Ownership and Acquisitions. JAMA Netw Open. 2019;2(5):e193987. doi:10.1001/jamanetworkopen.2019.3987

[32] Wang V, Maciejewski ML. Patient Outcomes and Dialysis Consolidation—Two Big to Fail? JAMA Netw Open. 2019;2(5):e193962. doi:10.1001/jamanetworkopen.2019.3962

commercial insurers paid an average rate per treatment four times higher than government programs in 2017.[33]

We applaud the work done by the Trump Administration to improve the delivery of kidney care and to re-evaluate the current state of ESRD care. As HHS Secretary Alex Azar has noted, "88 percent of Americans with ESRD start treatment with center-based dialysis. Just 12 percent start treatment at home with hemodialysis or peritoneal dialysis. This is the complete opposite of the situation in some of our peer nations, including Hong Kong, where more than 80 percent of patients benefit from some form of in-home dialysis. Improving this situation dramatically, as we ought to do, will mean examining the payment incentives in our programs today, while expanding access to new technologies."[34] We also applaud CMS for acknowledging that home dialysis is often preferred over facility-based dialysis by both patients and providers. Expansion of home dialysis and other alternative delivery methods is more important than ever during the COVID-19 public health emergency, as immuno-comprised and seriously ill individuals need access to treatment options that allow them to reduce their risk of exposure and practice social distancing.

Humana strongly recommends that CMS take immediate action to revise network adequacy standards for dialysis providers in time for 2021 plan bids. We believe advancements in dialysis technology and the expansion of options for providing dialysis treatment at home have reached a tipping point, and that modifications to network adequacy requirements are greatly needed for MA plans to deliver on the goals articulated in the Administration's Advancing American Kidney Health Initiative.

We provide more detailed comments on the specific policy options below:

Attestation: **Humana strongly supports the option to allow plans to attest to providing medically necessary dialysis services in its application (as is current practice for durable medical equipment, home health, and transplant service) instead of requiring each MA plan to meet time and distance standards for providers of these services.** Use of attestation would ensure that beneficiaries are able to access an adequate network of providers, without the unnecessary administrative burden of demonstrating compliance with specific time and distance standards. The attestation option allows MA plans to innovate in the provision of services at alternative sites of care such as micro-dialysis centers, home dialysis, and via telemedicine. Humana is committed to transforming the quality of care for dialysis patients and requests maximum flexibility in provision of services at the appropriate site of care. Under this approach, CMS would retain the ability under 42 C.F.R. § 422.510(a)(4)(vi) to sanction plans that do not ensure network adequacy, which creates a strong incentive for plans to comply with the requirements and attest accurately.

---

[33] Childers CP, Dworsky JQ, Kominski G, Maggard-Gibbons M. A Comparison of Payments to a For-profit Dialysis Firm From Government and Commercial Insurers. JAMA Intern Med. 2019;179(8):1136–1138. doi:10.1001/jamainternmed.2019.0431

[34] Alex M. Azar II, "Remarks to the National Kidney Foundation," March 4, 2019, available online at https://www.hhs.gov/about/leadership/secretary/speeches/2019-speeches/remarks-to-the-national-kidney-foundation.html

Other proposals: **We also strongly support the allowing exceptions to time and distance standards if a plan is instead covering home dialysis for all enrollees who need these services. This proposal, in conjunction with the proposed 85 percent threshold for non-urban providers and the proposed 10 percent time and distance credit in states with certificate of need laws, would preserve rigorous time and distance standards while making reasonable allowances for evolving models of care, such as home dialysis.**

Establishing Pharmacy Performance Measure Reporting Requirements (§ 423.514)

CMS proposes to establish a requirement for Part D sponsors to disclose to CMS the pharmacy performance measures used by plan sponsors to evaluate pharmacy quality performance. These measures would then be publically reported by CMS and could include performance calculation methodology, success/failure threshold(s) and the associated financial implications, pharmacy appeal requirements, and the mechanism of payment or collection. CMS notes that they will go through additional regulatory processes as required by the Paperwork Reduction Act (PRA) to define the required data elements.

Humana comments: **Humana appreciates the agency's efforts to balance its goal of improved transparency and predictability for pharmacies with the effort to promote quality initiatives in value-based payment to improve beneficiary health.** Humana's approach to performance-based agreements with network pharmacies closely aligns with our value-based payment initiatives for providers, hospitals, and other healthcare providers. In all of our value-based reimbursement programs, we seek to incent our partners to improve the quality of care delivered to our members by more closely aligning reimbursement with member outcomes. Humana's performance-based pharmacy network is also modeled, in part, on CMS's Star Ratings program.

Since the inception of our pharmacy performance program in 2017 (the Humana Rx Quality Network), we have seen meaningful changes in medication adherence and studies have shown that adherence results in better health outcomes and reduced hospitalizations. We believe that pharmacy performance, like plan performance, has a critical part to play in improving health outcomes for beneficiaries. Additionally, we've seen year-over-year improvement in the median pharmacy performance which is an indication that the program is meeting its goal of incentivizing pharmacy behavior and improving the quality of care provided to beneficiaries.

As part of our Quality Network Program, **Humana has developed transparency and support mechanisms to ensure that pharmacies participating in the program have the necessary information and tools to manage their performance, identify target metrics, and improve quality.** One of the resources offered to pharmacies is an online pharmacy performance dashboard published by a third party vendor. The tool provides pharmacies with the information necessary to track overall performance and identify members who are late to refill or non-adherent which may be impacting the pharmacy's ability to meet the target metrics. Additionally, Humana provides opportunities for pharmacies to engage directly with our Quality Network Program support team to discuss elements of their performance and opportunities for improvement. This is accomplished through a dedicated inbox supporting pharmacy inquiries and meetings upon request in which pharmacies can discuss their performance and other clinical initiatives related to Humana members. These resources have been put in place to support our pharmacy partners in jointly achieving an overall goal of improved care for our members.

When considering the pharmacy performance measure data that should be collected by CMS, **the agency should aim to provide information that is meaningful in nature and does not inappropriately disclose contracting terms**. If CMS is attempting to understand its stated goals on improved transparency and predictability of the pharmacy performance arrangements, including financial contracting terms would not likely provide those insights. We believe reporting the measure name, brief measure description, measurement period, and timing of collection and/or reconciliation would be most meaningful in improving transparency and predictability. If CMS elects to collect information related to the financial terms of the plan and pharmacy's agreement on performance, this information should not be shared broadly as it considered proprietary in nature. Currently, Humana reports our pharmacy contracting terms, which include the requested pharmacy performance financial information, to CMS through the MA plan application and document submission process.

CMS also plans to publically disclose the information reported by plan sponsors on pharmacy performance including the potential of the collection of retrospective information. As part of that process **CMS should take efforts to partner with plan sponsors to determine the format and medium that is most effective for communicating to both pharmacies and beneficiaries.** It will be important that this information is provided in a clear and representative manner that does not generate confusion for pharmacies or beneficiaries. Humana would be interested in coordinating with CMS on the most effective way to display pharmacy performance information.

Lastly, Humana appreciates the diligence that CMS is taking with allowing industry consensus on any measure before starting the PRA process. We encourage CMS to continue to collaborate with plan sponsors to determine a reasonable timeline for data collection as it completes additional administrative processes to obtain PRA authority to collect the required pharmacy performance information. **Given the current ambiguity on the data required and the data submission timeline, we do not recommend that CMS collect retroactive data until the performance year after the reporting requirements have been finalized.**

CMS encourages the industry to continue to work together on developing a set of pharmacy performance measures through a consensus process and Part D sponsors to adopt such measures to ensure standardization, transparency and fairness.

Humana comments: As active members of the Pharmacy Quality Alliance (PQA), Humana has been deeply engaged in their efforts to advance pharmacy accountability in value-based models. Humana is supportive of PQA's efforts and approach to build consensus on standardized measure concepts for utilization in pharmacy quality and value-based programs. However, we have concerns about the process to develop pharmacy performance measures and the initial proposal developed by PQA. **Humana does not believe that the proposed PQA measures will be suitable for improving quality, incentivizing pharmacy performance, and providing health plans with the necessary autonomy for use in the Medicare Part D program. We remain committed to partnering with PQA on building consensus around a viable solution that continues to enable broad pharmacy level accountability to enhance patient quality in the Medicare Part D program**.

Our primary concerns with the initial proposal include:

- **Reduced Plan Autonomy**: The proposal to utilize an all Medicare denominator limits plan data validation autonomy and creates perverse incentives for competing plan sponsors who may be required to compensate pharmacies for performance related to another plan's membership.
- **Limited Pharmacy and Measure Inclusion**: The proposed measures are very narrow in scope, ultimately limiting the ability of health plans to influence quality and establish pharmacy accountability in value-based arrangements.

Separately, **Humana also has concerns that the proposed measures do not represent an industry perspective** as the members of the working group who are developing the next phase of proposed measures include representatives from technology companies as well as drug manufacturers. We recommend that only plans and pharmacies participate in any effort to define the most appropriate terms for pharmacy level performance measures.

CMS provided recommended principles for pharmacy performance measures used in the Part D program and solicited comments on other considerations that should be taken into account when developing principles for pharmacy performance programs. The principles include:

- Improve medication use and outcomes for the beneficiaries served;
- Be specified at the right level of attribution and appropriate level of comparison considering pharmacy type;
- Factor in both pharmacy accountability and drug plan performance goals;
- Have clear specifications and be established prior to the measurement period;
- Be reliable, transparent and fair; and
- Use threshold minimums if appropriate.

Humana comments: Humana supports the spirit of many of these principles today. We encourage the agency to consider:

- **Incentivizing all pharmacies to invest in improving beneficiary outcomes:** All pharmacies should be incentivized through targeted performance measures to improve beneficiary outcomes through improved adherence.
- **Allowing plan flexibility and autonomy to shape pharmacy performance**: We believe that plan autonomy is essential to successfully developing our performance network. Our primary concern with the PQA proposal, is that plans will be required to compensate pharmacies based off of performance for another plan sponsors membership with an all Medicare denominator. We do not believe that establishes the appropriate incentives.
- **Alignment with other value-based contracting programs**: Pharmacy performance measures should also align with other value-based contracting programs on which plans and providers are evaluated. This will ensure that those in the quality improvement system are working toward common goals and can appropriately share in the benefits of improved health outcomes for beneficiaries.
- **Promoting innovation in value-based arrangements**: Additionally, the measures used in pharmacy performance arrangements should not be so rigid that they limit innovation between plans and pharmacies to promote better health.

CMS indicated that the agency may develop measures to consider for use in the Part D Star Rating program that, for example, may assess Part D plan sponsors' uptake of a standard set of pharmacy performance measures or that evaluate the percent of high-performing pharmacies in the sponsors' pharmacy network.

> **Humana comments:** Humana believes that alignment between pharmacy performance measures and the Star Rating program is important. However, **when considering if a Star measure on pharmacy performance is appropriate, CMS must ensure that there are appropriate incentives in place for plan sponsors and pharmacies alike**. For example, as industry standard performance measures have been developed by PQA, we have been concerned about the potential that some plan sponsors may be required to reimburse pharmacies based on performance for another plan sponsors' beneficiaries. If this was also the case for plan payment in the Star Ratings, this challenge would be amplified as some plans could be inappropriately compensated for a pharmacies performance related to another plan's members. Therefore, we do not believe that plan performance evaluation based on adoption is appropriate. Conversely, if a star measure was determined based on the number of high performing pharmacies in a plan's network, there could be an incentive for plan sponsors to lower the performance thresholds, which would result in less pharmacy accountability and lower quality. Given this, we encourage CMS to consider the unintended consequences of how a potential Star measure could impact the incentives for both plans and pharmacies.
>
> Additionally, **we do not believe that the use of a standardized set of pharmacy performance measures would be appropriate** in all situations. By defining a standard data set for pharmacy performance or defining the definition of a high performing pharmacy, CMS would be limiting the levers that plan sponsors and pharmacies could use to develop programs that would advance pharmacy performance and beneficiary outcomes. Furthermore, the generation of a standard data set in this fashion would be an infringement upon the contractual relationship between the plan sponsors and the pharmacies and could potentially limit future innovation to improve member outcomes.

CMS solicited comments for operational considerations on data elements, timeline, and method of submission for the reporting of pharmacy performance measures.

> **Humana comments**: **CMS should strive to make reporting of pharmacy performance measures as streamlined and consistent as possible with other reporting related to Part D plan performance reporting and Star Ratings**. CMS should also consider other larger scale transparency efforts from CMS and HHS on interoperability, Medicare Plan Finder, real time benefit tools that should use a similar format and syntax in reporting to ensure consistency. Lastly, we ask that CMS consider the infrastructure development that may be necessary to report this information in the time and manner required to do so effectively. We recommend that CMS engage with plan sponsors on these efforts as technology changes necessary for reporting requirements could take 9-to-18-months dependent upon the level of detail.

<u>Dismissal and Withdrawal of Medicare Part C Organization Determination and Reconsideration and Part D Coverage Determination and Redetermination Requests (§§ 422.568, 422.570, 422.582, 422.584, 422.590, 422.592, 422.631, 422.633, 423.568, 423.570, 423.582, 423.584, and 423.600)</u>
CMS proposes regulations for withdrawing or dismissing Part C organization determination and reconsideration requests and Part D coverage determination and redetermination requests. CMS also

proposes regulations for withdrawing or dismissing Part C and Part D independent review entity (IRE) reconsiderations.

Humana comments: Humana supports codifying the dismissal rules currently set forth in Parts C and D combined sub-regulatory guidance. While CMS notes, "These proposals would codify what we believe to be the current practices related to dismissal of Part C organization determination and reconsideration requests and Part D coverage determination and reconsideration requests, including those applicable to the Part C and Part D IRE," **Humana has identified several inconsistencies between the agency's proposal and existing sub-regulatory guidance.**

First, CMS proposes to use the dismissal process for withdrawals, stating "we are proposing to permit a plan to dismiss a request for the initial plan level decision … when … individual or entity who requested the review submits a timely **written** request for withdrawal of their request for an organization determination or coverage determination with the plan" (emphasis added). This is inconsistent with "Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance" (Released February 2019) which allows for verbal withdrawal. Section 40.14 provides the following:

> A plan may also choose to accept verbal withdrawal requests. For verbal withdrawal requests, the plan should clearly document in their system the date and the reason why the party chose not to proceed with the initial determination procedures. The plan should, but is not required to, send a written confirmation of that withdrawal to the party within 3 calendar days of receipt of the withdrawal request, clearly indicating which request is being withdrawn (i.e. name of drug or type of service or item requested).

Similarly, for first level appeals, §50.4 states as follows:

> The party who files a request for a level 1 appeal may withdraw the request in writing at any time before an appeal decision is mailed by the plan. A plan may also accept withdrawal requests verbally, provided that the plan mails a written confirmation of the withdrawal to the party within 3 calendar days from the date of the verbal request. The written confirmation should clearly indicate which request is being withdrawn (i.e. name of drug or type of service or item requested)

Humana requests CMS continue to permit verbal withdrawals in the spirit of "The key focus of this initiative is to reduc[ing] "red tape" that … wastes the time clinicians and other healthcare workers need to perform their primary mission—caring for patients." Often withdrawals come while providers are on the phone with the plan and to require them to subsequently submit a written request for withdrawal. To ensure transparency in the process, Humana would support requiring a written confirmation be mailed to the party within three calendar days from the date of the verbal request.

Second, as alluded to above, when written confirmation of an oral withdrawal is sent to the withdrawing party, no right to review by the Independent Review Entity (IRE) is provided pursuant to current subregulatory guidance. Pursuant to proposed §422.590, the dismissal notice must "give the enrollee or another party to the reconsideration the right to request review by the independent entity of an MA organization's dismissal of a request for a

reconsideration in accordance with §§ 422.582(f) and 422.584(g).” This would mean plans would be required to provide aforementioned rights upon receipt of a withdrawal request pursuant to proposed §§ 422.568(h), 422.582(g), 422.592(e), 422.631(f), 422.633(i), 423.568(j), 423.582(f), and 423.600(h). **Humana believes providing the party with the right to request review by the IRE may cause confusion as this is being withdrawn at their request.**

Furthermore, Humana notes that CMS proposes codifying four scenarios in which a plan is permitted to dismiss a request:

- The individual or entity is not a proper party
- The party failed to make out a valid request
- When the enrollee dies while the request is pending and the enrollee’s spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the reconsideration.
- When the individual or entity submits a timely written request for a withdrawal of the reconsideration.

Humana seeks clarification on whether this list is intended to be illustrative or if this is an exhaustive list in light of current sub-regulatory guidance. For example, in §50.8 of “Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance” (Released February 2019), “If an enrollee has requested a standard pre-service reconsideration but the MA plan becomes aware that the enrollee has obtained the service before the MA plan completes its reconsideration, processing stops and the MA plan must dismiss the request.”

Humana seeks clarification on proposed §§ 422.568(h), 422.582(g), 422.592(e), 422.631(f), 422.633(i), 423.568(j), 423.582(f), and 423.600(h) which provide that written notice of the dismissal must be delivered to the parties (either mailed or otherwise transmitted) to inform them of the action; this would include the individual or entity who made the request. Humana is proposing that this be modified to require notification to only interested parties. For example, when a non-contracted provider fails to submit a waiver of liability (WOL) within the required timeframe, the plan is to dismiss this case for failing to make a valid request. In such circumstances, it would not be appropriate to notify the member as they are not a party to the request – it is the provider seeking an appeal of their denial of payment, not the member’s liability.

While Humana supports codification of “the right of enrollees and other parties to request review by the independent entity of the MA organization’s dismissal of a request for a reconsideration in accordance with §§ 422.582(f) and 422.584(g),” it is seeking clarification on the comments leading into this proposal. CMS notes:

> Under existing rules at §422.590(a)(2), (b)(2), (c)(2), (d), (e)(5), and (g)63, if the MA organization makes a reconsidered determination that affirms, in whole or in part, its adverse organization determination, it must prepare a written explanation and send the case file to the independent entity contracted by CMS as expeditiously as the enrollee’s health condition requires, but no later than 30 calendar days from the date it receives the request for a reconsideration (or no later than the expiration of an applicable extension).

Humana notes that the timeframe described above is for a Part C standard pre-service reconsideration (§422.590(a)(2)). The timeframes set for the in §422.590 vary by case type (for Part B drug standard pre-service reconsideration (7 days), Part C post-service reconsideration (60 days), and expedited pre-service reconsiderations (24 hours from the affirmation of the original determination)). While Humana does not believe CMS intends to modify the timelines set forth in §422.590, it is seeking clarification.

VI. Codifying Existing Part C and D Program Policy

Maximum Out-of-Pocket (MOOP) Limits for Medicare Parts A and B Services (§§ 422.100 and 422.101)
CMS requires all MA plans to establish limits on enrollee out-of-pocket cost sharing for Parts A and B services that do not exceed the annual limits established by CMS. This proposal intends to regulate how these MOOP limits will be set for 2022 and subsequent years, including the impact of the 21st Century Cures Act on allowing ESRD members to enroll in MA plans starting in 2021.

CMS is proposing to codify existing methodology and establish a new third (intermediate) MOOP limit. CMS believes implementing more than two levels of MOOP and cost sharing limits would encourage plan offerings with lower MOOP limits and result in more favorable benefit designs for beneficiaries. CMS's goal is to support innovation, improve available benefit offerings, and provide beneficiaries with affordable MA plans that are tailored for their unique healthcare needs and financial situation.

Humana comments: We thank CMS for the additional transparency provided in setting the MOOP limits. Humana supports and appreciates the flexibility for MAOs to innovate, improve available benefit offerings, and provide beneficiaries with affordable MA plans tailored for their unique healthcare needs and financial situation. **Humana requests that final decisions related to this change be communicated as early as possible (ahead of the CY2022 Advance Notice Part II, or in the November/December Actuarial User Group Call) to allow for implementation and adequate testing of our tools ahead of the CY2022 bid season.**

Because of the change in eligibility requirements for MA plans regarding beneficiaries with diagnoses of ESRD, CMS is also proposing to include the out-of-pocket expenditures for beneficiaries with ESRD in the data used to set the MOOP limits. CMS notes that excluding the ESRD cost differential might serve to limit MA enrollee costs, but would not be consistent with ensuring access to affordable and sustainable benefit packages because MA plans will have to cover higher costs for beneficiaries with ESRD.

Humana comments: We thank CMS for the additional transparency provided in setting the MOOP limits. Additionally we thank CMS for taking into consideration the likely influx of ESRD beneficiaries into MA plans when calculating the mandatory MOOP limits.

Humana has concerns that the changes proposed to account for the increased cost to MA Organizations from enrollment of ESRD beneficiaries comes at a cost to non-ESRD members, such as:

- Using MA rebate dollars, normally used for benefit enhancements such as reduced cost sharing and Mandatory Supplemental Benefits, to cover ESRD costs included in the bid via the ESRD subsidy section in Worksheet 4 of the MA Bid Pricing Tool,
- MOOP limit increases that apply to all members regardless of ESRD/non-ESRD status, and

- Increases in Part C cost sharing limits that also apply to all members, regardless of ESRD/non-ESRD status. For example, proposed changes in Part C cost sharing for "Inpatient Hospital Acute - 60 Days" would result in maximum cost sharing that exceeds 100 percent of the Medicare FFS cost sharing for individuals without ESRD. [35]

We do not believe Congress intended that broadening ESRD beneficiaries' access to Medicare Advantage would harm current MA beneficiaries. **Rather than increasing costs for all non-ESRD beneficiaries, Humana recommends that CMS instead adopt policies that adjust payments to address higher ESRD beneficiary costs, without adversely affecting non-ESRD beneficiaries.** These alternate steps could include adjusting the ESRD dialysis benchmarks to account for the significantly higher plan cost due to MOOP requirements or creating a two year risk corridor program for MA ESRD experience. Both of these alternatives are described in our comments to Exclusion of Kidney Acquisition Costs From Medicare Advantage (MA) Benchmarks (§§422.258 and 422.306).

If CMS intends to finalize its proposed approach, it should consider increasing the percentage of the ESRD phase-in in 2021 from 40 percent to 50 percent, to at least match CMS's anticipated portion of ESRD migration in 2021. CMS should also adjust the proposed percentages for subsequent years accordingly. Phasing in the adjustment results in a MOOP that is too low and fails to achieve "an *actuarially equivalent* level [of] cost-sharing" with Original Medicare, as required by Social Security Act § 1852(a)(1)(B)(i).

Humana suggests CMS wait to finalize the full set of ESRD phase-in rules until the ESRD penetration rate in year one can be assessed. Moreover, the ultimate blending may be insufficient if the penetration rate of ESRD members in MA plans exceeds that of non-ESRD members. As more ESRD members migrate to MA plans, fewer will remain in Original Medicare. Because of this, a MOOP calculated using both non-ESRD and ESRD members could also be set too low, and thus fail to achieve an actuarially equivalent level of cost-sharing. There is the potential for this to occur given the substantial financial benefits of the MOOP for ESRD members.

On page 9075 of the Federal Register, CMS describes the steps for setting the lower and mandatory MOOP limits. In the fifth sub-bullet, when the non-ESRD MOOP methodology requires year over year changes due to non-ESRD costs falling outside the prescribed 95th and 85th percentiles, CMS proposes to postpone the ESRD phase in schedule until future years when the non-ESRD MOOP methodology does not require a MOOP change.

Humana comments: Humana suggests if CMS still finds it appropriate to incorporate any ESRD MOOP phase-in schedule like the one proposed in paragraph (f)(4)(vii), the schedule be enforced regardless of any year over year MOOP changes needed using the non-ESRD methodology when setting the 95th and 85th percentiles. We believe that it is necessary to keep any phase-in schedule adopted by CMS consistent year-over-year, as ESRD migration is happening separately from any changes to non-ESRD costs in setting the MOOP. Potential delays in the ESRD phase-in schedule could require additional member premium increases for non-ESRD members in order to fully subsidize ESRD member costs.

[35] CMS Memorandum: Contract Year 2021 Part C Benefits Review and Evaluation. Kathryn A. Coleman, February 6, 2020

Service Category Cost Sharing Limits for Medicare Parts A and B Services and per Member per Month Actuarial Equivalence Cost Sharing (§§ 422.100 and 422.113)

CMS imposes a number of requirements that apply to the cost sharing and benefit designs of MA plans. Specifically, ensuring MA organizations cover basic benefits with cost sharing that is at least actuarial equivalent to cost sharing in Original Medicare and imposes constraints on specific benefits to prohibit enrollment discrimination. Current methodology sets these limits using Medicare FFS data without ESRD based on the MOOP limits established by the MA plan. This proposal seeks to codify the existing methodology, with additional modifications to include ESRD members and create new limits for the introduction of a new third (intermediate) MOOP level found in Section VI.A.

> **Humana comments:** We thank CMS for the additional transparency provided in setting the defined cost sharing limits at each MOOP level. We note that proposed changes in Part C cost sharing for "Inpatient Hospital Acute - 60 Days" would result in maximum cost sharing that exceeds 100 percent of the Medicare FFS cost sharing for individuals without ESRD, resulting in cost sharing that is no longer actuarially equivalent for the non-ESRD population. We believe such a change could cause unintended disruption and/or unmanageable costs for beneficiaries. This issue is illustrative of the concerns we have in general with the changes proposed to address the increased MA plan cost due to changes in eligibility for beneficiaries with ESRD. Those changes involve various forms of subsidization by non-ESRD members, such as use of the ESRD subsidy in the Bid Pricing Tool, MOOP limit increases, and increases in Part C cost sharing limits. Such subsidization will likely result in both financial strain on MA organizations as well as beneficiaries, resulting in reduced competition and beneficiary choice.

CMS is also proposing to codify a longstanding interpretation of the current anti-discrimination provision for all service categories, in which payment of less than 50 percent of the total MA plan financial liability discriminates against enrollees who need those services, regardless of the MOOP limit. For services without defined CMS cost sharing limits, under this proposal, if the MA plan uses copayments, the copayment for an out-of-network benefit cannot exceed 50 percent of the average Medicare FFS allowable cost for that service area and the copayment for in-network benefits cannot exceed 50 percent of the average contracted rate of that benefit (item or service); if the MA plan uses coinsurance, then the coinsurance cannot exceed 50 percent.

> **Humana comments:** Humana is fully supportive of avoiding discrimination against enrollees who have high health care needs, and agree with codifying a limit of 50 percent cost sharing. Humana suggests allowing the average contracted rate to be calculated at the parent organization level for purposes of determining compliance with the 50 percent rule. This will allow MAOs the ability to consider credibility when setting cost sharing limits to help create cost sharing stability for beneficiaries year over year. Similarly, allowing for small rounding differences to the nearest $5 increment will also help with benefit design stability year over year.

CMS is also proposing codifying Per Member Per Month (PMPM) Actuarial Equivalent (AE) Cost Sharing Limits For Basic Benefits (§422.100(j)(2)) consistent with methodology previously released in the call letter, for inpatient hospital, SNF, DME and Part B drugs.

> **Humana comments:** Humana supports codifying the PMPM actuarial equivalent cost sharing limits for inpatient hospital, SNF, DME and Part B drugs. However, we request that CMS please

clarify if any adjustments were made to calculations/methodology used to compare PMPM plan cost sharing to adjusted Original Medicare AE cost sharing for the impact of ESRD members. In addition, CMS should clarify how the increases noted for inpatient Part C Cost Sharing Limits in Cost Sharing Limits for Inpatient Hospital Acute and Psychiatric Services (§422.100(f)(6)(iv)) on page 9080, which now include costs for ESRD members, impact the plan level inpatient calculations and limits for AE Cost Sharing.

Rewards and Incentives Program Regulations for Part C Enrollees (§ 422.134)

CMS proposes to codify existing policy related to rewards and incentive (R&I) programs for Part C enrollees.

Humana comments: Humana appreciates CMS' continued efforts to provide MAOs with the ability to create innovative programs to encourage beneficiaries to engage in activities targeted at improving their overall health. We believe these programs are an important element to shaping product offerings, enhancing the beneficiary experience, and improving health outcomes. Our specific experience with Part C incentive programs has demonstrated success in improving the results for our most historically non-compliant members on a variety of process and outcomes based measures.

Historically, Part D plans have been prohibited from offering R&I programs to encourage healthy behavior from beneficiaries. However, we believe there is ample opportunity to use rewards and incentives as a tool to improve beneficiary health and lower their out-of-pocket costs on prescription drugs. The inclusion of rewards and incentives would provide plan sponsors with a new tool to improve health outcomes, enhance medication adherence, and encourage beneficiaries to use lower cost therapeutic alternatives when available. One example of how R&Is could be used in Part D is to incentivize beneficiaries, especially those in the LIS population, to use lower cost therapeutic alternatives when available. By providing beneficiaries with R&Is in this scenario, plan sponsors will be able to directly share the resulting savings with beneficiaries, resulting in lower costs for beneficiaries and the Medicare program. As such, **we encourage CMS to provide plan sponsors with the flexibility to provide R&Is to beneficiaries in the Part D program.**

CMS proposes to require that MAOs provide accommodations to qualifying individuals who would otherwise be eligible for the reward but are unable to perform the target activity.

Humana comments: We support CMS' proposal to allow qualifying individuals to earn rewards through comparable activities and alternative methods of proof of participation. We recognize that circumstances vary widely among members, including access to resources traditionally required under R&I programs. Providing accommodations to those who wish to participate but are without the means to do so will allow the benefits of these programs to positively impact the health of a broader population of members.

In addition to permitting participation accommodations to members in certain circumstances, **Humana recommends that CMS allow MAOs to target members who are part of a higher risk or non-compliant population.** For example, rewarding members at risk for colon cancer for having a colonoscopy within the recommended timeframe or providing a higher reward for a member who gets a mammogram for the first time in three years, as opposed to a member who

receives a mammogram annually. This would allow opportunity to influence positive behavioral changes of individuals with the most serious health concerns.

CMS proposes that MAOs make information available to CMS upon request about the form and manner of any rewards and incentives programs that the MAO offers and any evaluations of the effectiveness of such programs.

Humana comments: Humana agrees with the proposal that MAOs make information available upon request, but we do not support additional mandatory reporting. **We believe it is sufficient for the purpose of monitoring and oversight that MAOs provide information upon request without the additional burden of a specific reporting requirement.**

CMS proposes to require that a reward or incentive be provided to an enrollee in the contract year in which the activity is completed.

Humana comments: Humana urges CMS to modify this proposal to permit sponsors to provide a reward or incentive "promptly" instead of within the contract year in which the activity is completed. CMS notes it proposed requiring delivery within the contract year to "ensure that rewards are timely provided to the enrollee."[36] While Humana recognizes the goal of ensuring enrollees receive the rewards they earned, it may be impractical for a sponsor to deliver within the contract year a reward earned within the last few days of the contract year. Humana believes requiring "prompt" or "timely" delivery would balance CMS's intent with this practical consideration.

CMS additionally proposes to require that a reward or incentive not have a value that exceeds the value of the target activity itself.

Humana comments: Humana respectfully urges CMS to clarify this proposal or retain its current requirement of a CMS-defined cap on the value of rewards. While there are some target activities with clear, easy to determine values, the value of many target activities, including examples used by CMS such as regularly checking blood pressure and regularly exercising, are difficult to ascertain even though such activities may reasonably be expected to produce meaningful savings in the aggregate through improved health and early detection of latent risks. We encourage CMS to define more clearly the flexibility sponsors have in determining the value of a target activity or, in the alternative, retain the current cap on reward value.

CMS proposes that an organization may not make mid-year changes to its R&I program.

Humana commentsf: Humana respectfully urges CMS to modify this proposal and permit sponsors to make mid-year changes to an R&I program. CMS notes R&I programs must be included in the plan bid each year as a non-benefit expense and that prohibiting mid-year changes ensures beneficiaries know what rewards and incentives are available at the time of enrollment. While Humana recognizes that the cost of such programs must be fixed in advance in order to be included in the plan bid, innovation occurs throughout the year, and limiting a sponsor's ability to modify or establish new rewards and incentives reduces a sponsor's flexibility to respond to changes in member behavior and to experiment with new approaches.

[36] 85 Fed. Reg. 9107.

Past Performance (§§ 422.502 and 423.503)

CMS proposes to eliminate the current past performance methodology for evaluating contract applications with a more streamlined methodology and define "failure to comply with a contract," which can be the basis for an application denial. CMS proposes a discretionary approach which would allow it to issue contract denials if the applicant: was subject to civil money penalties ("CMPs") or intermediate sanctions, has an overall Star Rating of lower than 3 stars, or fails to maintain a fiscally sound operation.

Humana comments: Humana appreciates and supports CMS' attempt to simplify the methodology. However, Humana respectfully recommends that CMS modify its proposal as follows:

CMS should clarify in the text of the regulation that it applies to the applicant MAO's performance under an existing contract, and not all contracts within the umbrella of the parent organization. Humana believes it is CMS' intent to assess past performance at the level of the MAO, not at the level of the parent entity. *See* 85 Fed. Reg. 9112 ("Our proposed policy at 42 CFR § 422.502(b) to deny applications based on past contract performance applies at the MA organization level"). This approach is appropriate and consistent with the scope of 42 CFR § 422.502(b), which evaluates the *applicant's* past performance. This differs from how CMS has previously evaluated contracts. We support this change as it appropriately focuses on the MA Organization that is submitting the application. Humana recommends that CMS clarify in the regulatory text that it will evaluate applications based on past performance under the applicant MAO's existing contracts.

CMS should limit the types of CMPs that give rise to denial. The proposed rule would authorize CMS to deny applications for *any* CMP, including ones that would not trigger denial under the current past performance methodology, no matter how small the amount or insignificant the issue. Furthermore, CMS' current regulations provide CMS with broad authority to levy CMPs.[37] The proposed rule creates a scenario in which a relatively minor compliance issue that gives rise to a small CMP could in turn give rise to denials of future contract applications. This is not possible under the existing Past Performance Methodology.

Denial of the application should be reserved for instances where there are significant compliance issues and should not exclude otherwise high performing plans from the program. Accordingly, Humana urges CMS to either establish a dollar value threshold or define certain types of serious compliance issues on which the CMP was based as sufficient to trigger contract or service area expansion (SAE) request denials. Such an approach would better protect beneficiaries from those MAOs with significant noncompliance, but would not unnecessarily limit beneficiaries' ability to benefit from expanded choice to plans that may have had relatively minor compliance issues that have been corrected.

CMS should limit denials based on low Star Ratings to MAOs that have had three consecutive years of an overall Star Rating lower than three. The proposed rule would allow CMS to deny applications for an MAO that has received a Part C or D summary-level Star Rating of lower than three during a twelve month review period. This is significantly more stringent than the current

[37] *See* 42 CFR § 422.752.

past performance methodology, where a low summary-level Star Rating on its own is never sufficient to trigger a denial at the contracting organization (legal entity) level.

As explained above, Humana supports CMS' proposal to evaluate past performance at the MAO level, rather than the parent organization level. However, CMS should limit denials to only those MAOs that have had three consecutive years of scoring less than three stars on their overall Star Rating. This would be consistent with the plans that are identified on Medicare Plan Finder as low performers. It would also more accurately identify plans with significant noncompliance and avoid depriving beneficiaries of access to plans that may have experienced one outlier year of lower performance, but otherwise have performed well.

CMS should tighten the basis for denial in order to minimize uncertainty and unpredictability. The proposed rule introduces unnecessary and undesirable uncertainty for MAOs planning service area or other expansions. It grants CMS broad discretion to deny or approve contract applications and SAE requests when a plan experiences one of these three issues, but provides no parameters for when CMS will choose to issue a denial. Without more parameters, as proposed above, as to when an application will be denied, many plans will be discouraged from investing the time and effort in preparing to expand. This chilling effect will limit the number of plan options available to beneficiaries and reduce competition. Humana respectfully urges CMS to refine the thresholds for circumstances that will trigger denials of contract applications and SAE requests.

Prescription Drug Plan Limits (§ 423.265)

CMS proposes to codify existing sub-regulatory guidance that would limit Part D sponsors to offering no more than three prescription drug plans per PDP region, including one basic plan and up to two enhanced alternative (EA) plans.

Humana comments: Humana opposes limiting the number of prescription drug plan offerings in the stand-alone PDP market to three. This policy, in its existing form, has limited beneficiary choice and innovation from plan sponsors. Instead, **Humana recommends that the agency remove the meaningful difference requirement and allow for plan sponsors to offer two basic plans, one for low-income beneficiaries and another for non-low-income beneficiaries, in addition to a wider array of enhanced alternative plans.** We believe that this combination of plan offerings will result in a greater amount of beneficiary choice as well as additional innovation all at a similar cost to the government. **We also encourage CMS to simultaneously review other policies that have limited plan sponsors from offering beneficiaries a wider array of PDP choices**.

CMS states that the agency has "made consistent efforts to ensure that the number and type of PBPs PDP sponsors may market to beneficiaries are no more numerous than necessary to afford beneficiaries choices from among meaningfully different plan options."

Humana comments: Much of CMS' concern about the number of plan offerings stems from the policy goal to ensure that plans offered to beneficiaries in the Part D program are meaningfully different and not confusing to beneficiaries. Humana supports this effort to ensure that beneficiaries are given the proper information about their choices for prescription drug coverage and, as CMS states, are "afforded choices from among meaningfully different plan options."

However, **there are flaws in the methodology that CMS uses to determine meaningful difference** that fail to account for variation between plans that are in fact meaningfully different to beneficiaries. CMS' meaningful difference assessment is based solely off of out-of-pocket costs at preferred retail pharmacies and does not account for other factors in the benefit structure such as mail order benefits, network composition, or additional benefits which all make a meaningful difference in a beneficiary's experience. In examining the trends in the market, beneficiaries have clear preferences for the pharmacies in the network and mail order opportunities that are available when selecting their prescription drug coverage. For example, a beneficiary who is home-bound or has limited access to a vehicle or a local pharmacy is likely to find meaningful value out of a PDP plan that offers mail order benefits. The current meaningful difference calculation does not take this into account when assessing the variation in the plans offered by a plan sponsor. **We believe that CMS' decision to relax meaningful difference requirements for EA plans was appropriate – we encourage the agency to take a similar approach when considering the possibilities to expanding the number of basic plans offered to beneficiaries.**

Additionally, **CMS can take action to enhance the tools that are made available to beneficiaries as they are selecting plans in the Medicare program**. During the 2020 Annual Election Period (AEP) the Plan Finder tool had significant challenges that removed some of the functionality that would make it possible for beneficiaries to identify differences in plan offerings including mail order offerings and deductible amounts.[38] We're encouraged by CMS' recent efforts to engage stakeholders to continue to discuss opportunities to improve Plan Finder and other digital tools to enhance the shopping and plan selection experience.

CMS notes that plan sponsors were previously allowed to offer more than one basic plan to be offered in a PDP region but retracted the policy as it felt that plan sponsors were not offering meaningfully different plan options that satisfied actuarial equivalence.

Humana comments: Humana believes that the optimal plan offerings would allow for two basic plans – one for low-income subsidy (LIS) and one for non-low-income subsidy – which will force plans to compete to develop plan offerings tailored to meet the needs of certain beneficiary populations. There is precedence for this type of model within the MA program with D-SNP plan offerings. It will also allow plan sponsors to develop interventions to more effectively manage the LIS population which currently accounts for over 70 percent of program spending.[39] One of the ongoing challenges in the Part D program is the increasing cost of reinsurance. According to analysis from the Kaiser Family Foundation, 72 percent of reinsurance spending in 2017 was on LIS beneficiaries.[40] Despite this, there are very few tools in place today for plan sponsors to effectively manage the behavior of low income beneficiaries in Part D. The addition of an LIS-only plan offerings could help address this programmatic issue in the Part D program.

[38] https://khn.org/news/website-errors-raise-calls-for-medicare-to-be-flexible-with-seniors-enrollment/
[39] http://files.kff.org/attachment/Data-Note-How-Many-Medicare-Part-D-Enrollees-Had-High-Out-of-Pocket-Drug-Costs-in-2017
[40] http://files.kff.org/attachment/Data-Note-How-Many-Medicare-Part-D-Enrollees-Had-High-Out-of-Pocket-Drug-Costs-in-2017

As part of the proposal, CMS indicates that it does not believe that the segmenting risk within the Part D program obtains the most value for the government or the taxpayer. However, this belief comes with the assumption that future plan design would not be tailored to meet the needs of complex and high cost populations like the LIS population – which is largely restricted by CMS today. If plan sponsors were permitted to design plans that specifically targeted the needs of the low income population, there would be an opportunity to reduce overall costs while simultaneously providing a more tailored benefit package which could drive both improved health outcomes for beneficiaries and reduced costs for the government and the tax payer.

According to internal Humana analysis, **creating a low-income only basic plan and a non-low income basic plan would have the same net cost for the government and offer beneficiaries more targeted benefits to suit the population.**[41] This could be done by requiring plan sponsors to offer a second basic plan that is limited to dual eligible auto-assign beneficiaries. We recommend that this be a requirement for all plan sponsors in order to maintain a level playing field for the assignment of auto-enrollments of LIS members. In the absence of such a requirement, plans could strategically avoid low income subsidy enrollments. We envision that if LIS auto-enrollment was aligned to a tailored benefit package, plan sponsors would have the opportunity to shape a plan that drives to the lowest overall cost for the government by maximizing price negotiations. Opportunities for shaping specific plans for LIS beneficiaries could include:

- **Opportunities for shared savings:** Plan sponsors could provide low income beneficiaries with an opportunity to share in the savings associated with the use of lower cost therapeutic through rewards and incentives.
- **Further reductions in co-pays*:*** Plan sponsors could provide further reductions in co-pays for low-income beneficiaries on targeted medications to improve adherence through an LIS-only plan which would not encounter challenges with uniformity of benefit requirements.
- **Additional benefits to address social determinates of health*:*** As part of our work to address population health, we have also considered how other elements of a beneficiary's environment contribute to overall health. Some of the potential items that could be included would be enhance mail-order services for homebound beneficiaries or opportunities to support beneficiaries with food insecurity and/or other community resources.

Offering a targeted benefit to low income beneficiaries, would also benefit non-low income beneficiaries. Non-low income beneficiaries would still have access to a basic plan offerings that meet the standard benefit package that are available today and in some cases, that basic plan may come with a lower premium – ultimately resulting in more low premium options for beneficiaries.

CMS seeks comments on the impact of limiting the number of enhanced plan offerings to two, expanding the number of enhanced plan alternatives, and whether there is a need for more than two standalone enhanced plan options per PDP sponsor per PDP region.

[41] Humana analysis using Humana's Basic PDP as a proxy for the industry's basic PDP offering.

Humana comments: As previously stated, the three plan limit has limited beneficiary choice and innovation from plan sponsors. The impact of limiting the number of EA plan offerings to two will further limit plan sponsors from being able to meet beneficiary needs and preferences which continue to change with a more service-centric aging population. Additionally, the agency fails to acknowledge the impact that this policy has on the ability of plans to maintain competition based on premium without disruption of a large number of beneficiaries from one plan year to the next. Given this, **we recommend that CMS allow for more than two EA plans, as it will allow plans sponsors to:**

- **meet evolving beneficiary needs and preferences;**
- **allow for plans to effectively manage maturing plans; and**
- **offer new to market products without creating beneficiary disruption.**

Evolving Beneficiary Needs and Preferences

As a new generation of seniors are entering the Medicare program, there are evolving beneficiary needs and preferences from their prescription drug plan. Proprietary market research performed on behalf of Humana indicates that beneficiaries are interested in greater variation in the products offered in Part D. The **research found that beneficiaries believe the optimal number of choices in Part D would include five different PDPs spanning across health status complexity and customer service variation**. An increasing number of seniors have indicated that they are interested in a more convenient and service oriented PDP. Conversely, there was still a significant portion of beneficiaries who were driven by lowest possible cost. These findings are illustrated by market actions in 2019 when 28 percent of PDP enrollees in regions with new products were enrolled in a new PDP offering due to the elimination of the meaningful difference requirement for enhanced alternative (EA) PDPs.[42] The current market cannot meet these separate, and in some ways competing, beneficiary preferences with a limited number of plan offerings. **It can materialize with a wider selection of plan offerings, which aligns with a spirit of the Part D program where private plans compete to provide beneficiaries with prescription drug coverage through a wide array of plan choices.**

Additionally, CMS also reconsider other policies that have inhibited PDP sponsors' ability to offer value and choice for beneficiaries and for the government. The MA program has developed a wide array of choices to support beneficiary needs and has significant flexibility to offer supplemental benefits ranging from dental and vision to programs to address social determinates of health. This same variation has not occurred in the standalone PDP market due to the restrictions that CMS has placed on plan sponsors. **We encourage CMS to examine additional policies that have limited innovation in the standalone PDP market including:**

- **Supplemental Benefits**: PDP sponsors are currently unable to file supplemental benefits like those that are frequently used in the MA program. CMS could continue to create another layer of competition in the PDP market by allowing plan sponsors to offer these types of services. For example, one service that could be offered to beneficiaries with food insecurity is access to a healthy food card for use with medications that are

[42] Humana analysis of CMS State County Contract Enrollment File from January 2019 available here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-PDP-Enrollment-by-State-County-Contract.html

required to be taken with food. Humana has experience developing food based programs for beneficiaries in MA which have resulted in reductions in medical costs. [43]

- **Inclusion of Rewards and Incentives**: Adding rewards and incentives to encourage beneficiary behavior changes would provide plan sponsors with an additional lever that can improve health outcomes, enhance medication adherence, and help drive beneficiaries to lower cost therapeutic alternatives. One challenge faced by many plan sponsors are efforts to incentivize beneficiaries to use lower cost therapeutic alternatives, especially for those in the low income population. We believe that allowing plan sponsors to reward beneficiaries for taking action to lower their out-of-pocket costs as an untapped tool to lower Medicare spending on prescription drugs. By providing beneficiaries with rewards and incentives in this scenario, plan sponsors will give beneficiaries the opportunities to share in the savings associated with selecting a lower cost therapeutic alternative.

- **Targeted Programs for Low-Income Beneficiaries:** Low-income beneficiaries are more likely to use brand name drugs as opposed to generics due to a co-pay structure that provides limited opportunities to influence meaningful behavioral changes. [44] Currently, plan sponsors are not permitted to design targeted programs for these beneficiaries – due to the uniformity of benefits requirements – that may provide them with greater incentives to select lower cost therapeutic alternatives like $0 copays – similar to a 2016 recommendation from MedPAC.[45] Allowing plan sponsors to implement programs like this would reduce out-of-pocket costs for low income beneficiaries while also providing savings to the government in the form of reduced reinsurance spending – 72 percent of which is attributed to low-income beneficiary spending.[46]

- **Network Design:** Additionally, there could be additional flexibility in pharmacy network design that could better serve beneficiaries seeking innovative plan design choices. This could be structured as a program that focuses on specific disease states, preferred pharmacy networks, or a mail order benefit that mimics the Tricare program. Such plan designs could offer beneficiaries protections that allow for access outside of the network when unexpected circumstances are present.

Challenges with Maturing Plans

Each year, plan sponsors re-evaluate bids based on the relative age and health of the enrolled beneficiaries. In standalone PDPs there are very few beneficiaries who voluntarily change their prescription drug coverage each year. For example, in 2017 only 10 percent of stand-alone PDP

[43] Study performed on behalf of Humana found that members who received the Well Dine meal delivery service within 30 days of being discharged from the hospital had a 2.2 percent reduction in readmission rates and $411 decrease in inpatient spending over a 90 day period.

[44] http://www.medpac.gov/docs/default-source/reports/jun19_ch2_medpac_reporttocongress_sec.pdf

[45] http://www.medpac.gov/docs/default-source/reports/chapter-6-improving-medicare-part-d-june-2016-report-.pdf

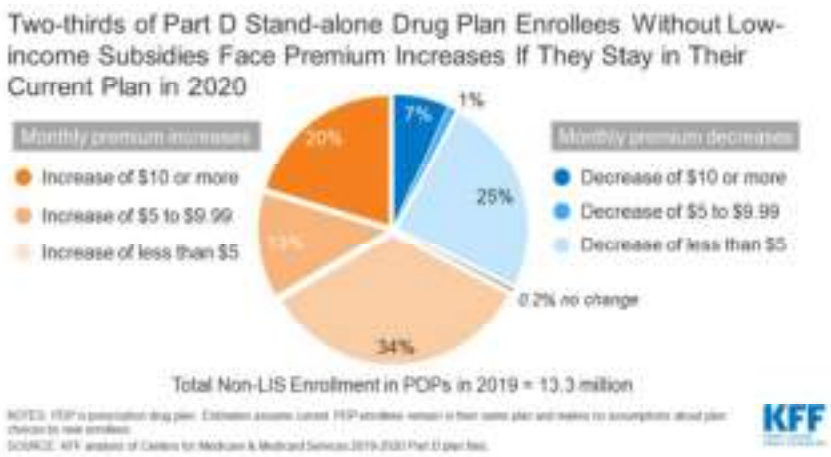
[46] Kaiser Family Foundation June 2019 Data Note http://files.kff.org/attachment/Data-Note-How-Many-Medicare-Part-D-Enrollees-Had-High-Out-of-Pocket-Drug-Costs-in-2017

beneficiaries voluntarily switched to a new plan.[47] Therefore, PDP that have been offered by plan sponsors for several years are likely to have a population of enrolled beneficiaries who are older with more complex healthcare needs than plans that are newer to the marketplace. There is a compounding year over year effect as only a small portion of beneficiaries have voluntarily dis-enrolled annually since the initial offering. This ultimately results in plan sponsors being forced to increase premiums in order to serve the enrolled population. According to analysis from the Kaiser Family Foundation (KFF), two thirds of non-low income beneficiaries enrolled in standalone PDPs in 2020 will experience a premium increase if they stayed in their current plan.[48]

[47] See: https://www.kff.org/medicare/issue-brief/no-itch-to-switch-few-medicare-beneficiaries-switch-plans-during-the-open-enrollment-period/

[48] See: https://www.kff.org/report-section/medicare-part-d-a-first-look-at-prescription-drug-plans-in-2020-issue-brief/

Premium Changes for Stand-alone PDPs in 2020



KFF's findings are also consistent with our own internal analysis which found that in each of the last four years 60 percent of beneficiaries on average were expected to experience a premium increase in the following year if they remained in their current plan. These points coming together – the rate of plan maturity and the associated premium increases combined with the three plan limit – makes it challenging for plan sponsors to continue to offer low premium standalone PDPs without creating beneficiary disruption through merging other plans. Allowing additional plan offerings would provide plan sponsors with another tool to continue to bring new low premium products into the standalone PDP market to provide greater choice while minimizing any adverse premium impacts to beneficiaries who do not choose to change their coverage.

Potential Beneficiary Disruption

Humana appreciates CMS' concern on how the number of plan offerings impact government spending and provides incentives for plan sponsors to effectively compete in the market on premium. However, the current structure of the Part D benefit does not allow plan sponsors to continue to compete on premium without disrupting beneficiaries – especially given challenges with maturing plans. **Under the current requirements, it is difficult for plan sponsors to evolve and test different plan offerings to support evolving beneficiary needs without creating disruption.** For example, if a sponsor currently offers two EA PDPs and wants to develop a new plan offering – that could potentially help beneficiaries lower their out of pockets costs for prescription drugs – the plan sponsor must either merge two existing plans together or terminate an existing plan in order to offer a new plan benefit package. Merging and terminating plans creates disruption for beneficiaries, who will be forced to move from their current plan.

The example below illustrates how allowing for more plans will create the flexibility for plan sponsors to meet the beneficiary's evolving market needs through new benefit designs while also creating minimal disruption. The boxes highlighted in pink represent the merging plans and the potential premium changes if there were a greater number of plans in the market. In this example in the current requirements as (Table 1), the merger of two EA plans would result in a $15 premium increase for some beneficiaries. If there were more plan offerings as outlined in

the potential future model (Table 2), the magnitude of merging plans would result in smaller premium increases in the event that plans are merged. Ultimately this model will create additional low premium plan offerings, as shown in the blue boxes in Table 2, and provide beneficiaries with more opportunities to reduce their spending on prescription drugs.

Table 1 Current Requirements*

		Basic	EA1	EA2	EA3
Year 1	Plan Premium	$30	$30	$60	N/A
	Population	1,000	1,000	1,000	N/A
		Basic	**New Plan at AEP**	**Combined EA1 and EA2**	**EA3**
Year 2	Plan Premium	$30	$15	$45	N/A
	Population	1,000	0	2,000	N/A
	Premium Increase YoY	$0	$0	$15	N/A

Table 2 Potential Future Model*

		Basic	EA1	EA2	EA3
Year 1	Plan Premium	$30	$20	$40	$60
	Population	1000	666	666	666
		Basic	**New Plan at AEP**	**EA1**	**Combined EA2 and EA3**
Year 2	Plan Premium	$30	$15	$20	$50
	Population	1000	0	666	1332
	Premium Increase YoY	$0	$0	$0	$10

* The population numbers reflect the offering at the time that plan benefit packages are loaded into Plan Finder. Therefore, it assumes that there is a direct crosswalk for beneficiaries in merged plans and that new plans will have zero enrollment.

www.wakely.com

Star Rating Variability of Patient Experience and Access Measures

Analyzing the Impact of Variable Star Rating Cut Points and Measure Level Results

America's Health Insurance Plans

April 3, 2020

Developed by:
Wakely Consulting Group, LLC

Suzanna-Grace Sayre, FSA, MAAA, CERA
Senior Consulting Actuary

Dani Cronick, FSA, MAAA
Consulting Actuary

Wakely

Table of Contents

Executive Summary 2
Introduction and Background 4
Summary of Key Findings 6
Conclusion and Key Takeaways 10
Disclosures and Limitations 11
Appendix A – Methodology and Key Assumptions 13
Appendix B – Measure Level Results 15

Executive Summary

Wakely performed an analysis evaluating changes in measure level cut points over time and the resulting impact on Star Ratings for Medicare Advantage Organizations (MAOs). The focus of this report is Patient Experience and Complaints measures as well as Access Measures. The Centers for Medicare & Medicaid Services (CMS) will increase the weight of these measures from 1.5 to 2.0 for the 2021 Star Ratings. In addition, CMS has proposed a further increase in these measure weights to 4.0 in the Contract Year 2021 and 2022 Medicare Advantage and Part D Proposed Rule.[1] If implemented, these measures will have the largest weighting in the Overall Star Rating calculation. Below are the key findings from this analysis:

Although measure level data and performance has been relatively stable for Patient Experience/Complaints and Access measures, measure-level Star Ratings have been volatile.

After comparing average contract measure performance and Star Ratings, we determined contract Star Ratings are volatile year-over-year even while contracts have steadily improved in average measure values. This observation is particularly notable for Access Measures. The year-over-year change in cut points contributes to the observed volatility, and results in a disconnect between contract performance and contract scores, or Star Ratings.

Increasing the weight of Patient Experience/Complaints and Access measures could introduce greater instability to the Overall Star Ratings.

Our findings suggest that increasing the weights of the Patient Experience/Complaint and Access measures[2] will result in Star Ratings that are increasingly based on a set of measures for which there is evidence of material year-over-year volatility. The correlation between average contract performance and Star Ratings for these measures is unclear. Further study of the observed volatility and lack of correlation between performance and measure-level Star Ratings (based on current clustering methodology) is merited.

Figures 1 and 2 below demonstrate the volatility of these measures and disconnect between performance and ratings. All average results presented below are weighted equally across all contracts in order to be consistent with the weighting CMS uses in the clustering methodology. In other words, contracts are not weighted based on contract enrollment.

---

[1] https://www.federalregister.gov/documents/2020/02/18/2020-02085/medicare-and-medicaid-programs-contract-year-2021-and-2022-policy-and-technical-changes-to-the

[2] Throughout this paper, D02: Appeals Auto-Forward and D03: Appeals Upheld have been removed from summarized results because they will be removed from the Star Rating system beginning in 2022.

Figure 1
Patient Experience/Complaints Measures[3]

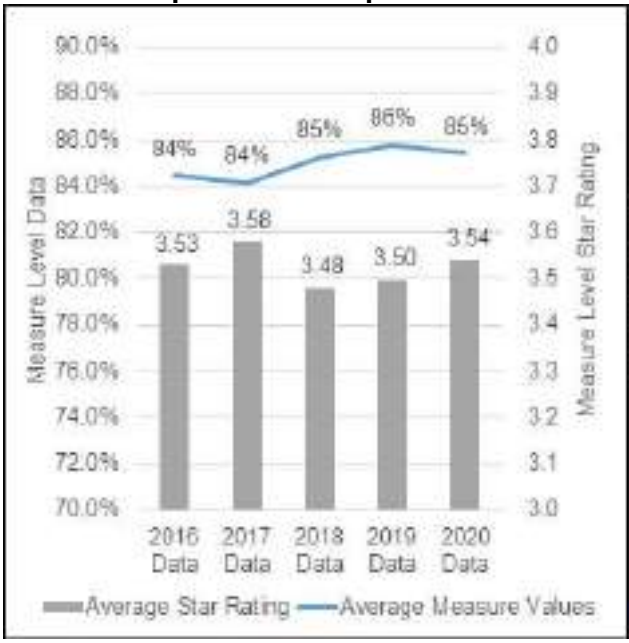
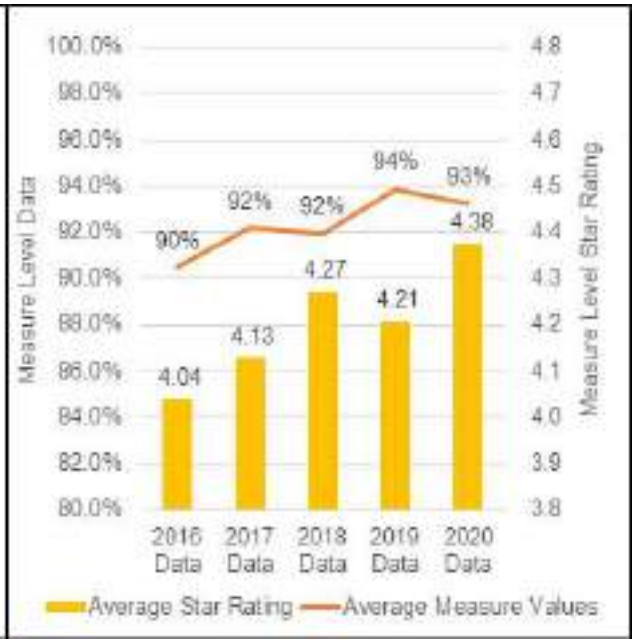


Figure 2
Access Measures[4]



Introduction and Background

The CMS Star Rating system was introduced in 2008 and began impacting MA spending in 2012. The system is designed to measure two major components of Medicare Advantage (MA) and Prescription Drug Plans (PDPs): 1) the quality of health and drug services received by beneficiaries, and 2) the experiences of enrolled beneficiaries.

The Star Ratings include measures applying to the following five broad categories:

1. **Outcomes**: Outcome measures reflect improvements in a beneficiary's health and are central to assessing quality of care.
2. **Intermediate Outcomes:** Intermediate outcome measures reflect actions taken which can assist in improving a beneficiary's health status.
3. **Process:** Process measures capture the health care services provided to beneficiaries which can assist in maintaining, monitoring, or improving their health status.
4. **Patient Experience and Complaints:** Patient Experience and Complaints measures reflect beneficiaries' perspectives of the care they received.

[3] Patient Experience/Complaints Measures are sourced from CAHPS surveys and CMS administrative data.

[4] Access Measures are sourced from data collected by CMS contractors.

5. **Access:** Access measures reflect processes and issues that could create barriers to receiving needed care.[5]

In addition to these categories, the Star Ratings include Part C and Part D improvement measures derived through comparisons of a contract's current and prior year measure scores across the majority of measures in the categories described above.

Table 1 shows the number of measures in each category under the 2020 Star Rating system, along with the weighting of each measure.

Table 1 –Stars Measures, 2020 Star Rating System

Star Rating Category	Number of Measures	Weight per Measure	Total Weight	% of Overall Star Rating
Outcomes	3	3.0	9.0	12%
Intermediate Outcomes	5	3.0	15.0	19%
Process	19	1.0	19.0	25%
Patient Experience and Complaints	10	1.5	15.0	19%
Access	6	1.5	9.0	12%
Improvement	2	5.0	10.0	13%

When combined, the Patient Experience/Complaints and Access measures represent 31% of the 2020 Overall Star Rating. CMS has proposed a significant weighting increase for these measures in the 2023 Star Rating system. Table 2 shows the proposed 2023 Star Rating weights for each measure category.

Table 2 –Stars Measures, 2023 Star Rating System (Proposed)[6]

Star Rating Category	Number of Measures	Weight per Measure	Total Weight	% of Overall Star Rating
Outcomes	3	3.0	9.0	8%
Intermediate Outcomes	5	3.0	15.0	14%
Process	19	1.0	19.0	17%
Patient Experience and Complaints	10	4.0	40.0	37%
Access	4	4.0	16.0	15%
Improvement	2	5.0	10.0	9%

If the weighting changes are implemented as outlined in the Proposed Rule, MAO contract performance in the Patient Experience/Complaints and Access measures will represent 52% of

[5] All results in this report exclude Access measures D02: Appeals Auto-Forward and D03: Appeals Upheld because CMS will remove these measures from the 2022 Star Ratings.
[6] With the exception of the two measures described above, this table contains only the proposed weight changes in 2023 and does not account for measures that will be added or removed between the 2020 and 2023 Star Ratings.

the 2023 Overall Star Rating. This is a significant increase, making the stability and predictability of these measures even more critical to ensure the stability of the Star Rating system.

America's Health Insurance Plans (AHIP) retained Wakely Consulting Group, LLC (Wakely), to analyze the variability in measure level cut points and performance over time for the Patient Experience/Complaints and Access Measures. MAOs use Star Ratings to gauge their over performance relative to other contracts, and variability in the cut points makes it more difficult for contracts to track changes in performance over time and make it difficult to compare performance relative to industry benchmarks. Also, to the extent beneficiaries use the Star Ratings program to aid in choosing between MA plans during the annual open enrollment period, variability in the cut points can make it difficult for beneficiaries to easily compare performance between plans via Star Ratings over time.

The remainder of this report analyzes the changes in measure level cut points and the impact that these changes have on MAO Star Ratings.

Summary of Key Findings

In order to observe the changes in contract quality performance and measure level Star Ratings, Wakely first gathered all available data from 2016 through 2020 Star Ratings and aggregated measure level performance, cut points and Star Ratings. For a full description of our methodology and assumptions, see Appendix A.

Volatility of Measure Level Data and Scores

Although there was not significant volatility in actual contract performance over time, the measure level Star Ratings connected to these performance results did vary. Figures 1 and 2 from the executive summary demonstrate the changes in average measure level performance and Star Ratings over time, shown separately for Patient Experience/Complaints and Access measures.

The measure level values in each year were averaged across all contracts and measures within each of the two categories. The majority of measures are "higher is better" measures, where a higher value indicates better performance; however, there are a few measures where "lower is better", i.e. a lower value indicates better performance. One example of these measures is C28: Complaints about the Health Plan. For these measures, we adjusted the values to:

$$\text{Lower is Better Adjusted Measure Value} = (1 - [\text{CMS Published Measure Value}])$$

After applying this change, we are able to combine the adjusted "Lower is Better" measure values with "Higher is Better" measure values in the same weighting category. We then calculate an average measure value across all contracts and all measures in the Patient Experience/

Complaints and Access measure categories.[7] We can also interpret an increase in the average measure value over time as an improvement, on average, in these categories.

Both Figures 1 and Figures 2 show there have not been large changes in average measure values between 2016 and 2020. The Patient Experience and Complaints Measures stay consistently between 84% and 86% in every year, and the Access measures show relatively steady improvement from 90% in 2016 to 93% in 2020.

Appendix B contains more detail on the historical performance of each Stars measure that contributes to the average Patient Experience/Complaints and Access measure values.

Figure 1 shows that average contract Star Ratings remained relatively unchanged for the Patient Experience and Complaints measures between 2016 and 2020. Although there have been slight changes in the unrounded average Star Rating each year, the rounded average Star Rating has remained at 3.5 every year.

Figure 2 shows that the average contract Star Rating for the Access measures has significantly more variability. The rounded average Star Rating varies from 4.0 in 2016, 2017, and 2019, to 4.5 in 2018 and 2020.

Contracts at each Measure Level Star Rating

Along with the variance in average measure level Star Ratings, the portion of contracts receiving each Star Rating changes materially from year to year. Figures 3 and 4 represent the number of contract measures assigned to each Star Rating across all measures within the Patient Experience/Complaints and Access measure groups.

[7] Measures that are on raw scale from 1 to 100 (rather than a percentage basis) were divided by 100 in order to maintain a consistent scale of 0 to 1 across all measures.

Figure 3 – Percent of Contract Star Ratings
Patient Experience and Complaints Measures[8]

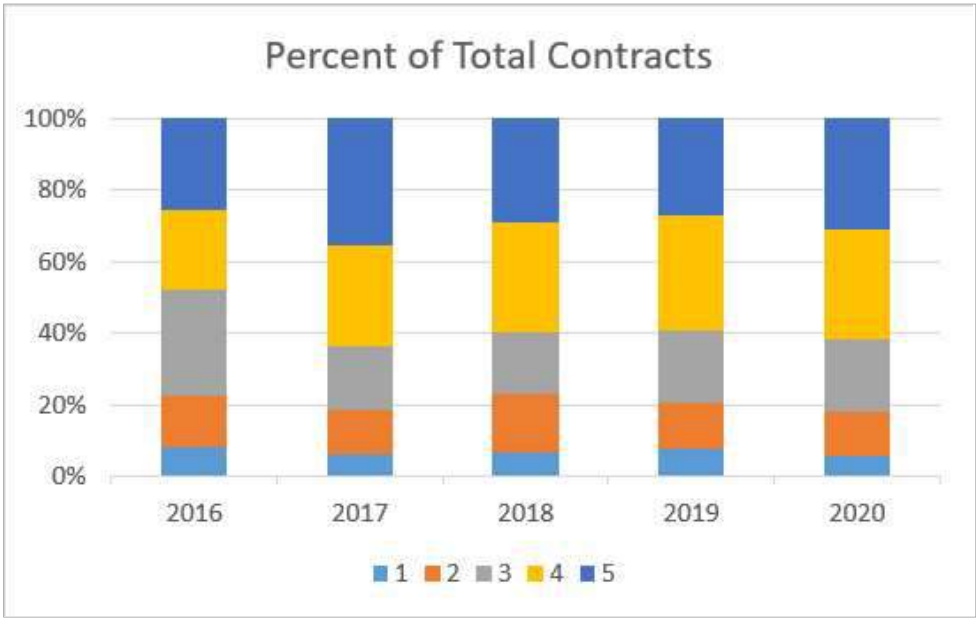
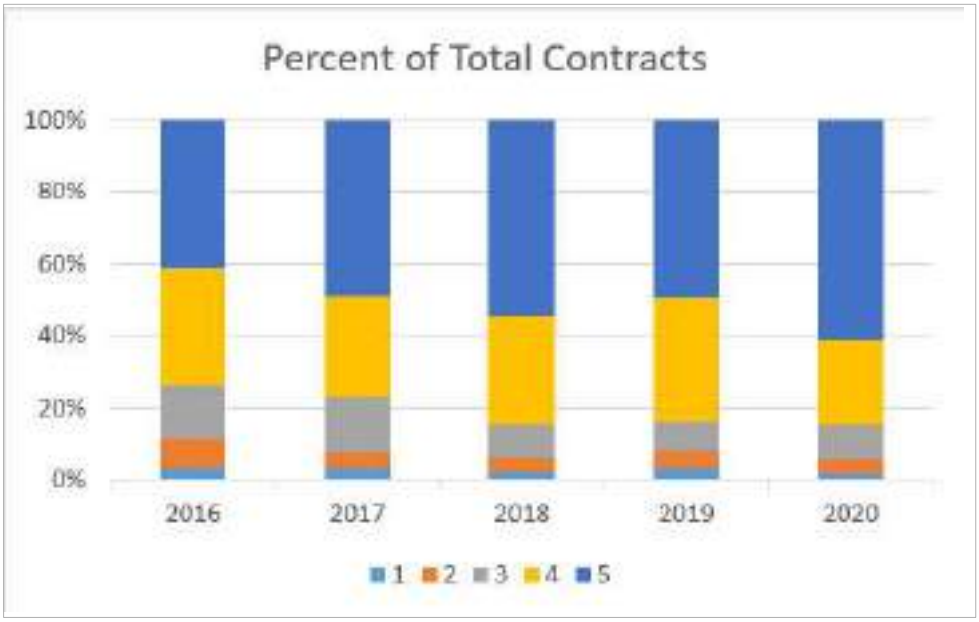


Figure 4 – Percent of Contract Star Ratings
Access Measures[9]



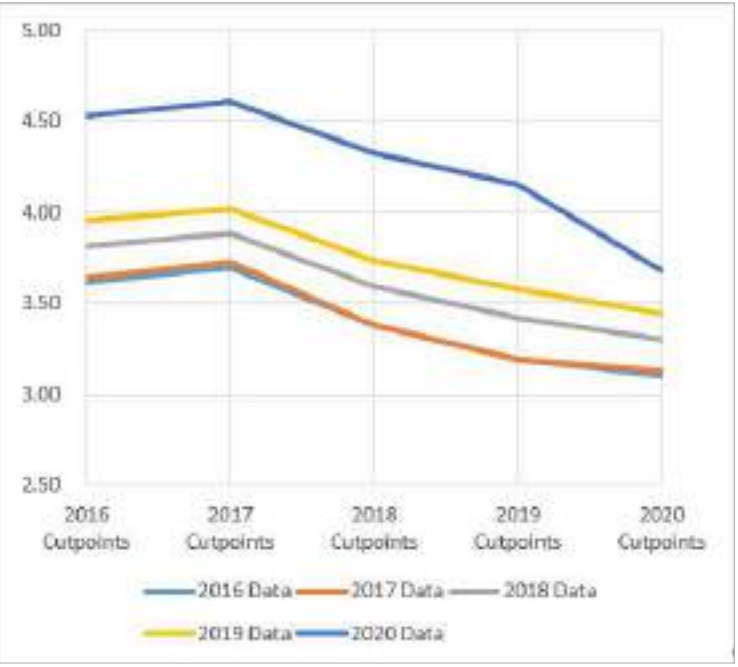
[8] Patient Experience/Complaints Measures are sourced from CAHPS surveys and CMS administrative data.
[9] Access Measures are sourced from data collected by CMS contractors.

Figures 3 and 4 illustrate the variability of Star Ratings from year to year. In particular, the portion of contracts that receive a 5.0 Star Rating varies widely each year. The portion of contracts receiving 5.0 Stars in Patient Experience and Complaints measures increased from 26% in 2016 to 36% in 2017, despite very little change in the weighted average value of these measures over the same time period from 84.4% to 84.2%.[10] Similarly, the Access measures experienced a small decrease in average value from 2017 to 2018,[11] but the portion of contracts with a 5.0 Star Rating increased from 49% to 55%. The volatility in contract Star Ratings is mainly driven by changes in cut points from year to year.

Impact of Changing Cut Points on 2020 Contract Level Performance

Finally, we used the measure level data from 2016 through 2020 and applied the changing cut points over the same time period. The darker blue lines in Figures 5 and 6 below represent the 2020 measure data applied to the cut points in each Star Rating year from 2016 through 2020. For example, average contract performance in the 2020 Patient Experience and Complaints measures, using the 2020 cut points, resulted in an average Star Rating of 3.68, but this same level of performance would have resulted in an average Star Rating of 4.53 using the 2016 cut points.

Figure 5 –Average Star Ratings
Patient Experience and Complaints Measures



[10] The change in average values described here is illustrated in Figure 1.
[11] The increase in average measure values is illustrated above in Figure 2.

Figure 6 –Average Star Ratings
Access Measures

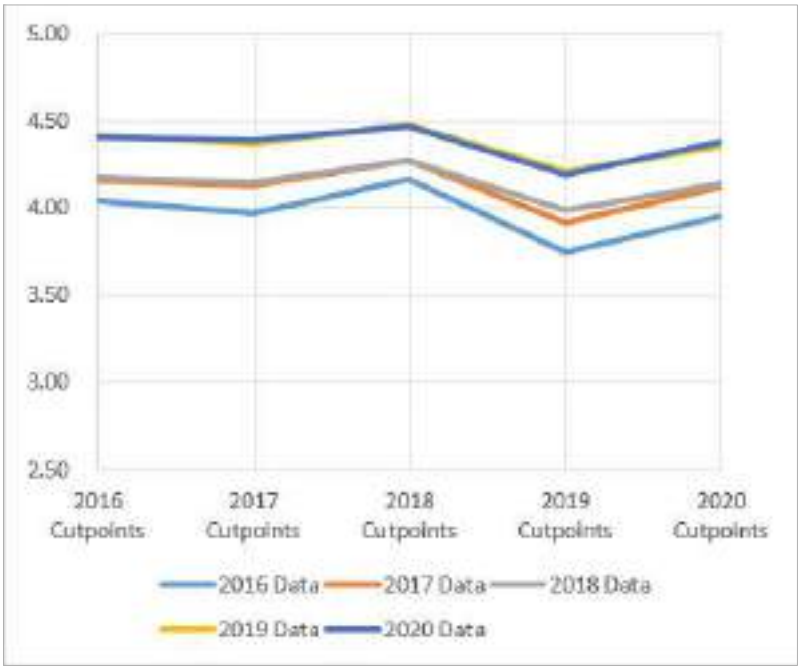


Figure 5 illustrates a significant decline in average Star Ratings for the Patient Experience and Complaints measures, even when keeping average contract performance in these measures constant. This large change over five years indicates the material impact of cut point changes on contract Star Ratings.

The Access measures trends in Figure 6 show a different pattern. Cut points for these measures have not steadily increased over time, and the average contract Star Ratings have increased or decreased in a seemingly random pattern each year, despite the fairly consistent improvement in measure level performance shown earlier in Figure 2. If an individual contract had consistent performance each year, its Star Rating would still increase or decrease purely due to cut point changes.

Conclusion and Key Takeaways

With the proposed increase in weight to the Patient Experience/Complaints and Access Measures in the 2023 Star Ratings, these measures will become more heavily weighted than any other measure groups. It is critical to understand the drivers of historical cut point volatility in these measures, and how this volatility impacts overall Star Ratings.

Historical cut point volatility in Patient Experience/Complaints and Access measures have contributed to volatility and inconsistent trends in contract Star Ratings.

There has been significant year-over-year volatility in average Star Ratings for Patient Experience/Complaints and Access measures, despite relatively consistent trends in plan performance over time. This volatility is primarily driven by the use of the clustering methodology, which has resulted in cut points that are not well correlated to changes in contract performance each year.

An increase in the weighting of Patient Experience/Complaints and Access measures could bring further instability to MAO Star Ratings.

As the intended purpose of the Star Ratings program is to compare contract performance on measures related to beneficiary health outcomes and experience, increasing the weights for these measures has the potential to erode the stability of the Star Ratings program by basing the majority of the Star Rating score on measures that have historically shown significant Star Rating volatility despite relatively stable performance in measure level data.

Disclosures and Limitations

Responsible Actuary Suzanna-Grace Sayre and Dani Cronick are the actuaries responsible for this communication. They are both Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the sole use of the America's Health Insurance Plans (AHIP) and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. We acknowledge that AHIP may provide the report to their participating health plans. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their actuarial experts in interpreting results. This information is confidential and proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this analysis are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. **Actual results may vary, potentially materially, from our estimates.** Wakely does not warrant or guarantee the projected values included in the analysis. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest We are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent to AHIP.

Data and Reliance We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any

independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Subsequent Events There are no known relevant events subsequent to the date of information received that would impact the results of this analysis. Differences or updates in the assumed contracts or risk and utilization of populations may cause deviation in results.

Deviations from ASOPS Wakely completed the analysis using sound actuarial practice. To the best of my knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations.

Appendix A - Methodology and Key Assumptions

In order to summarize the historical changes in measure level data as well as cut point and Star Rating changes, Wakely first gathered all publically available data for the 2016 through 2020 Star Ratings including measure level data, measure level cut points, measure level scores (Star Ratings), and overall Star Ratings. Because measures are added and removed over time, we focused the analysis on the most recent measures in the 2020 Star Ratings and compared performance using the same measures in prior years. Historical measures that were removed from the Star Rating system prior to the 2020 Star Rating year are not included in any of the summarized data presented in this report.

Summarizing Measure Level Data

For the majority of this report, measure level data and results is summarized at the weighting category level. For some measures, higher values do not achieve a higher Star Rating (e.g., for Plan All-Cause readmission, having a *lower* rate is better, but for Breast Cancer screenings, having a *higher* rate is better). In order to aggregate across all measures within a given category, we made several adjustments.

For measures where “higher is better” and the measure is on a 0-100% scale, no changes were made. For measures where “lower is better”, we calculated an adjusted measure value equivalent to one minus the measure level rating. After making this adjustment, higher values consistently indicate better quality performance in all measures. Finally, for measures where the data is reported a whole number instead of a percentage (e.g., in the 2020 Star Ratings, “Getting Needed Care” is a number from 1 to 100), the measure data was divided by 100 to adjust contract performance to a scale equivalent with the other measures.

After applying these adjustments, contract level data was then summarized for each year using a straight average approach. The weighted average approach was used to best align with how members and Medicare Advantage Organizations would be impacted by these results. Enrollment was pulled from December of each Star Rating year. For 2020, February Enrollment was used.

Applying Cut Points

After summarizing the publically available Star Rating data, we applied the measure level cut points for 2016 through 2020 to the measure level performance data from 2016 through 2020. The result was 25 different sets of measure level Star Ratings – 5 years of performance data times 5 years of cut points. The goal of this process was to determine:

1. If measure level performance were held constant over time (contracts did not have any improvement or deterioration in quality), how would their measure level Star Ratings change due to the changes in cut points alone?

2. If cut points were held fixed, how would measure level Star Ratings change over time due to changes in measure level performance alone?

For non-CAHPS measures, this involved selecting a period for the measure level data (e.g., in 2016 contract H1111 received 80% on the Breast Cancer Screening measure), and selecting a period for the measure level cut points (e.g., based on the 2018 cut points, an 84% would have yielded a 4 Star Rating for contract H1111 Breast Cancer Screenings Measure).

CMS applies a reliability factor to CAHPS measures that affects the assignment of measure level Star Ratings. It is not possible to calculate the reliability factor using the published Star Rating data, so we applied a simple calculation to derive the reliability factors. For each data year, the contract and measure level data for all CAHPS measures was compared to that year's measure level cut points and published measure level Star Ratings. When the resulting Star Rating did not match the published Star Rating, a reliability adjustment between -1 and +1 was derived to align the calculated Star Rating to the published Star Rating. This process was applied at the measure and contract level for all CAHPS measures, on all data years. The CAHPS reliability adjustment was then applied to the recalculated Star Ratings for every year (e.g., a 2016 CAHPS reliability adjustment was calculated based on 2016 data and 2016 cut points. This adjustment was then applied to the 2016 data with 2017 cut points, the 2016 data with 2018 cut points, and so on.). This approach assumes that the reliability factor remains constant even when measure level cut points change.

Exclusions and Caveats

There were several exclusions that were made for the purpose of this report. The focus of this report is MAO contract performance, therefore we have excluded Part D Plans (PDPs) from the analysis.

Appendix B – Measure Level Results

While the remainder of the report shows the change in average Patient Experience/Complaints and Access measures over time, this appendix illustrates each measure within these categories and the changes in measure level data and Star Ratings. The average amounts at the bottom of each table utilize the uniform metric described in Appendix A, where "Lower is Better" measures are inverted so that the average is one minus the published "Lower is Better" measure.

Figures B1 and B2 show the measure level data from 2016 through 2020 for Patient Experience/Complaints Measures and Access Measures.

Figure B1 – Patient Experience and Complaints Measure Data

Patient Experience and Complaints Measures	Data Source	Higher is Better?	2016 Data	2017 Data	2018 Data	2019 Data	2020 Data
C22: Getting Needed Care	CAHPS	Yes	83%	83%	83%	83%	83%
C23: Getting Appointments and Care Quickly	CAHPS	Yes	76%	76%	78%	78%	78%
C24: Customer Service	CAHPS	Yes	88%	88%	90%	90%	91%
C25: Rating of Health Care Quality	CAHPS	Yes	86%	86%	86%	86%	86%
C26: Rating of Health Plan	CAHPS	Yes	85%	84%	86%	86%	86%
C27: Care Coordination	CAHPS	Yes	85%	85%	86%	86%	86%
C28: Complaints about the Health Plan	CTM[1]	No	21%	24%	19%	17%	19%
C29: Members Choosing to Leave the Plan	MBDSS[2]	No	11%	11%	11%	10%	12%
D07: Rating of Drug Plan	CAHPS	Yes	84%	84%	84%	85%	85%
D08: Getting Needed Prescription Drugs	CAHPS	Yes	90%	91%	90%	90%	90%
Average of All Patient Experience and Complaints Measures			**84.4%**	**84.2%**	**85.2%**	**85.8%**	**85.4%**

[1] Complaints Tracking Module
[2] Medicare Beneficiary Database Suite of Systems

000713

Case 1:23-cv-03910-CJN Document 31 Filed 04/16/24 Page 291 of 717

Figure B2 – Access Measure Data

Measures Capturing Access	Data Source	Higher is Better?	2016 Data	2017 Data	2018 Data	2019 Data	2020 Data
C31: Plan Makes Timely Decisions about Appeals	IRE[3]	Yes	94%	94%	92%	96%	96%
C32: Reviewing Appeals Decisions	IRE	Yes	89%	90%	89%	91%	92%
C33: Call Center – Foreign Language Interpreter and TTY Availability	Call Center	Yes	89%	93%	93%	94%	93%
D01: Call Center – Foreign Language Interpreter and TTY Availability	Call Center	Yes	89%	92%	93%	94%	92%
Average of All Access Measures[4]			**90.5%**	**92.2%**	**92.0%**	**93.9%**	**93.2%**

[3] Independent Review Entity
[4] D02: Appeals Auto-Forward and D03: Appeals Upheld were both removed from this analysis since they are Access Measures that will be removed from the Stars Calculation for 2022 Star Ratings

000714

Case 1:23-cv-03910-CJN Document 31 Filed 04/16/24 Page 292 of 717

Figures B3 and B4 show the measure level Star Ratings from 2016 through 2020 for Patient Experience/Complaints and Access measures.

Figure B3 – Patient Experience and Complaints Measure Star Ratings

Patient Experience and Complaints Measures	Higher is Better?	2016 Star Ratings	2017 Star Ratings	2018 Star Ratings	2019 Star Ratings	2020 Star Ratings
C22: Getting Needed Care	Yes	3.5	3.3	3.4	3.3	3.3
C23: Getting Appointments and Care Quickly	Yes	3.4	3.3	3.3	3.4	3.4
C24: Customer Service	Yes	3.5	3.3	3.4	3.4	3.5
C25: Rating of Health Care Quality	Yes	3.4	3.4	3.4	3.3	3.3
C26: Rating of Health Plan	Yes	3.3	3.2	3.2	3.3	3.2
C27: Care Coordination	Yes	3.4	3.4	3.3	3.4	3.4
C28: Complaints about the Health Plan	No	3.9	4.6	4.3	4.1	4.9
C29: Members Choosing to Leave the Plan	No	4.2	4.3	4.0	3.9	3.9
D07: Rating of Drug Plan	Yes	3.3	3.3	3.2	3.2	3.0
D08: Getting Needed Prescription Drugs	Yes	3.4	3.6	3.4	3.5	3.5
Average of All Patient Experience and Complaints Measures		**3.8**	**3.53**	**3.58**	**3.48**	**3.50**

Figure B4 – Access Measure Star Ratings

Patient Experience and Complaints Measures	Higher is Better?	2016 Star Ratings	2017 Star Ratings	2018 Star Ratings	2019 Star Ratings	2020 Star Ratings
C31: Plan Makes Timely Decisions about Appeals	Yes	4.1	4.0	4.0	4.2	4.5
C32: Reviewing Appeals Decisions	Yes	3.6	4.0	4.0	4.0	4.1
C33: Call Center – Foreign Language Interpreter and TTY Availability	Yes	4.3	4.2	4.5	4.3	4.3
D01: Call Center – Foreign Language Interpreter and TTY Availability	No	4.2	4.3	4.5	4.3	4.6
Average of All Access Measures		**4.04**	**4.13**	**4.27**	**4.21**	**4.38**

000715

Case 1:23-cv-03910-CJN Document 31 Filed 04/16/24 Page 293 of 717

www.wakely.com

Proposed Rule Changes to the Medicare Star Rating Program

Analyzing the Impact of Proposed Changes on Medicare Advantage Spending

America's Health Insurance Plans

March 20, 2020

Developed by:
Wakely Consulting Group, LLC

Suzanna-Grace Sayre, FSA, MAAA, CERA
Senior Consulting Actuary

Dani Cronick, FSA, MAAA
Consulting Actuary

Table of Contents

Executive Summary 2
Introduction and Background 4
Comparison of CMS and Wakely Methodologies 5
Summary of Key Findings 7
Conclusion and Key Takeaways 11
Disclosures and Limitations 11
Appendix 1 – Finalized 2021 and 2022 Star Rating Changes 13
Appendix 2 – Methodology and Key Assumptions 14

Executive Summary

Wakely conducted a high-level analysis of the Star Rating program changes outlined in the Contract Year 2021 and 2022 Medicare Advantage and Part D Proposed Rule[1] issued by the Centers for Medicare & Medicaid Services (CMS). This report includes estimates of the impact that the proposed changes in the Proposed Rule would have on Medicare Advantage Organizations' (MAO) Overall Star Ratings, and the resulting impact to Medicare Advantage (MA) spending. If adopted, the 2023 Star Rating changes will impact MA spending in the 2024 payment year. The proposed changes were each viewed in isolation as well as combined. While the report goes into greater depth, below are the key finding from this analysis:

Increasing Patient Experience/Complaints and Access Measure Weights from 2.0 to 4.0 would increase MA Spending by less than the CMS estimate.

If this proposed change had been implemented for the 2020 Star Ratings, the change would be an increase to 2024 MA spending of $83.0 million, or $0.30 per member per month (pmpm), resulting in net cost to CMS. This value is far lower than the change of $391.4 million that CMS estimated in the Proposed Rule. The approach we used to estimate this change matches the CMS methodology, with a few key differences.[2] The valuation of this change does not include consideration of other Star Rating changes, and we did not incorporate the addition, removal, or weight changes of other measures that will occur prior to the change in Patient Experience and Access Measures.

Deleting Tukey Outliers from the Clustering Methodology would decrease MA Spending by more than the CMS estimate.

After incorporating the impact of mean resampling and cut point guardrails to the 2020 Star Ratings (a finalized change to go into effect in the 2022 Star Ratings), the incremental impact of Tukey outlier deletion would be a decrease to 2024 MA spending of $1.4 billion, or $5.24 pmpm, resulting in additional net savings to CMS. This value is significantly larger than the net savings of $808.9 million estimated by CMS in the Proposed Rule. As with the change in Patient Experience/Complaints and Access measure weights, this estimate is based on Wakely's interpretation of CMS's methodology. Other than mean resampling and cut point guardrails, this estimate does not incorporate other finalized Star Rating changes.

---

[1] https://www.govinfo.gov/content/pkg/FR-2020-02-18/pdf/2020-02085.pdf

[2] There may be several differences between the CMS and Wakely valuations, including but not limited to: a different base Star Rating year used to estimate the change (CMS used 2018, Wakely used 2020) and differences in 2024 enrollment and spending projections. Further detail around CMS and Wakely methodology and assumptions is included later in the report.

The combined Star Rating System Changes would decrease MA Spending by more than the CMS estimate.

After combining the two proposed Star Rating changes described above, the resulting impact is a decrease to 2024 MA spending of $1.1 billion, or approximately $4.10 PMPM[3]. This is a significantly larger figure than the net savings of $417.5 million estimated by CMS in the Proposed Rule, and a significantly higher cost to the MAOs. Based on our analysis methodology, which considers the composite impact of the expected methodological changes to be implemented by 2024 payment year, it is possible that CMS has materially understated the impact to MA plan sponsors. While we acknowledge that the order of operations may influence component impact estimates, the aggregate estimated impact of proposed changes published in the Proposed Rule is materially lower than Wakely's estimate.

As noted above, these estimates differ significantly from those published in the Proposed Rule. We attempted to match the CMS methodology in our estimates wherever possible. Table 1 summarizes the differences in these estimates. Note that the combined impact is less than the sum of the two proposed changes. When combined with the increase in Patient Experience and Access measure weights, the impact of Tukey outlier deletion is dampened as these measures become a smaller portion of weighting in the Overall Star Rating calculation.

Table 1 – Differences in the Estimated Impact of Proposed Star Rating Changes

	Impact to 2024 Medicare Advantage Spending	
Proposed Change	CMS Estimate	Wakely Estimate
Increasing Measure Weights	$391.4 million	$83.0 million
Tukey Outlier Deletion	$(808.9) million	$(1,443.8) million
Combined Impact	$(417.5) million	$(1,130.5) billion

CMS has not provided enough information on methodology and assumptions for other parties to independently validate or recreate the results.

There are several areas where CMS does not provide clarity on the methodology used to estimate the impact of these changes. A description of the items that are missing or unclear is included below in this report.

[3] The combined estimate also includes the impact of Mean Resampling and cut-point guardrails on the 2020 Star Ratings.

Introduction and Background

America's Health Insurance Plans (AHIP) retained Wakely Consulting Group, LLC (Wakely), to review the impact of the Star Rating changes in the Contract Year 2021 and 2022 Medicare Advantage and Part D Policy and Technical Changes to the Medicare Advantage Program (hereafter referred to as the "Proposed Rule"), issued by the Centers for Medicare & Medicaid Services (CMS) on February 18, 2020[4]. If finalized, CMS estimates that the proposed changes will result in an estimated $4.4 billion in savings to the federal government over ten years. The majority of these savings arise from changes to the MA and Part D Quality Star Rating system.

The CMS Star Rating system was introduced in 2008 and began impacting MAO spending in 2012. The system is designed to measure two major components of Medicare Advantage (MA) and Prescription Drug Plans (PDPs): 1) the quality of health and drug services received by beneficiaries, and 2) the experiences of enrolled beneficiaries. Over the past few years, CMS has implemented several changes to the Star Rating system with the goal of improving accuracy and stability. Appendix 1 contains a summary of the finalized changes that will take effect in the 2021 and 2022 Star Rating years.

If adopted, the 2023 Star Rating changes described in the Proposed Rule would impact MA spending in the 2024 payment year. The changes include:

- **Increasing Patient Experience/Complaints and Access Measure Weights from 2.0 to 4.0.** This change represents an additional increase beyond the change finalized in the April 2018 rule, which increased the weights of these measures from 1.5 to 2.0. The majority of these measures are CAHPS surveys of health plan members. CAHPS surveys focus on the quality of care from the perspective of patients, such as access to care and care coordination issues. The increase in measure weights will impact the calculation of the overall and summary Star Ratings, not the measure-level Star Rating assignment.
- **Deleting Tukey Outliers from the Clustering Methodology**. As part of an ongoing effort to increase predictability and stability of the Star Rating system, CMS has proposed Tukey outer fence outlier deletion[5]. If implemented, the Tukey method will represent an additional step to the clustering methodology, to be applied prior to the application of mean resampling and five (5) percent guardrails. Removing contracts with outlier measure scores from the clustering methodology will impact the assignment of Star Ratings at the measure level as well as the calculation of the overall and summary Star Ratings.

[4] https://www.cms.gov/newsroom/fact-sheets/contract-year-2021-and-2022-medicare-advantage-and-part-d-proposed-rule-cms-4190-p-1

[5] The Tukey Outer Fence method flags observations outside of a range calculated as a multiple of the interquartile range, and designates these observations as "outliers". CMS has proposed a multiple of 3.0 to identify outlier data points.

- **Remove the Rheumatoid Arthritis Management measure.** The National Committee for Quality Assurance (NCQA) is retiring this measure from the HEDIS measurement set for 2021 due to multiple concerns that the performance on the measure may not reflect the rate at which members get anti-rheumatic drug therapy. The removal of this measure will impact the calculation of the overall and summary Star Ratings.

Comparison of CMS and Wakely Methodologies

Wakely attempted to match the methodology used by CMS to estimate the changes described in the Proposed Rule throughout this analysis, with a few key differences. Table 2 describes both known and unknown differences in data, methodology, and assumptions between Wakely estimates and the methods described by CMS in the Proposed Rule. These differences should be carefully considered before comparing Wakely and CMS estimates.

Table 2 – Key Differences in CMS and Wakely Methodologies

Method/Assumption	CMS	Wakely	Potential Impact on Results
Mean Resampling and Guardrails Consideration for mean resampling and guardrails in the estimate of the proposed Tukey outlier deletion change	**Unclear** CMS proposes to amend the outlier definition to apply Tukey outlier deletion prior to mean resampling and guardrails, which were already finalized in the 2019 Final Rule[6].The estimate of Tukey outlier deletion does not clearly state whether the impact of mean resampling and guardrails is included.	**Yes** Wakely applied mean resampling and guardrails to the 2020 Star Rating cut points prior to applying Tukey outlier deletion, therefore the estimate of the Tukey outlier deletion impact does not include the impact of mean resampling and guardrails.	**High** Star Rating program changes have compounding impacts on results. Consideration for measure level changes set to occur would alter results.
Deviation from Published Clustering Methodology	**Unclear** For several of the 2020 Stars measures, it does not	**Published CMS Cut Points** Wakely used the published cut points	**Medium** The Wakely estimate of Tukey outlier impacts may be

[6] https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf

Method/Assumption	CMS	Wakely	Potential Impact on Results
	appear that CMS uses the methodology published in the Star Ratings Technical Notes. These measures include C14, C29, C31, D04, and D09[7].	for these measures without any adjustments.	understated because we do not consider any changes to the cut point for these measures.
Enrollment and Revenue Growth Assumptions	**Unclear** CMS only notes that the United States Per Capita Cost (USPCC) growth rates and county-specific quality bonus payments were used.	**Wakely 2024 Benchmark Rate Projections** No explicit Enrollment Growth assumed vs. 2020 enrollment Revenue growth assumptions include consideration of benchmark growth, future ACA caps, and current 2020 county-level contract enrollment.	**Medium**
Base Data Cut Points Estimation of Star measure cut points on the base data, without considering any changes from the Proposed Rule	**Stars Measure Data for All Contracts**	**Stars Measure Data for Published Contracts Only** CMS does not publish measure data for all contracts, therefore it is not possible for Wakely to match the published cut points exactly.	**Low** Wakely normalized the results to account for the difference in derived cut points.

[7] C14 - Diabetes Care – Kidney Disease Monitoring, C29 - Members Choosing to Leave the Health Plan, C31 - Plan Makes Timely Decisions about Appeals, D04 - Complaints about the Drug Plan, D09 - MPF Price Accuracy

Method/Assumption	CMS	Wakely	Potential Impact on Results
Star Rating Data Data used for the analysis of Tukey outlier deletion, mean resampling, and guardrails	**2018 Star Rating Data**	**2020 Star Rating Data** Wakely utilized the most recent Star Rating Data that is publicly available.	**Unknown** Wakely did not test the impact of the difference in Star Rating data.

Summary of Key Findings

Other than the known deviations described above, we attempted to replicate the logic CMS used to support estimations in the Proposed Rule. For a full description of our methodology and assumptions, see Appendix B. The following scenarios were tested in the order described below:

Recalculated 2020 Star Ratings Cut Points Using the Public CMS Measure Data Set

It is not possible to replicate CMS's cut point calculations exactly because CMS excludes some contracts' Stars measure data from the published data set. To evaluate the impact of each Star Rating program change, we first ran the clustering methodology on the published 2019 and 2020 Star Rating measure data. This gave us slightly different results than the published 2019 and 2020 cut points. We used the new set of cut points in each subsequent step of Star Rating changes. This step was necessary to ensure that all subsequent changes to cut points determined using the published data – guardrails, mean resampling, and Tukey outlier deletion – were capturing only the impact of the Star Rating change, and not the impact of the difference between published Star Rating cut points and our calculations on the limited public data set. After applying the recalculated cut points, the total estimated 2024 MA spending changed by -0.4%. We then applied a contract-level adjustment to bring each contract back to its published Overall Star Rating for 2020. This method of normalization resulted in a set of contracts with the same contract-level and total 2024 estimated revenue as that which is implied by the published 2020 Star Ratings.

Applied 2023 Star Rating Changes Described in the Proposed Rule.

- **Increasing Patient Experience/Complaints and Access Measure Weights from 2.0 to 4.0.** There are currently 11 Part C measures and 7 Part D measures in the 2020 Star Ratings that are classified as Patient Experience/Complaints or Access measures. These measures are currently 33% of the Overall MA-PD Star Rating

weights. In the 2021 Star Rating year, these measure weights will change from 1.5 to 2.0, bringing their total weight to 40%. If implemented, changing the weight of these measures from 2.0 to 4.0 in the 2023 Star Ratings will bring these measure weights to 53% of the Overall MA-PD Star Rating.

If this change were implemented for the 2020 Star Ratings, without applying any other proposed 2021 and 2022 Star Rating changes, 16.5 percent of MA–PD contracts and 9.5 percent of members would have seen their Star Rating increase by 0.5 Stars, and 2.5 percent of contracts, as well as 3.9 percent of members, would decrease by 0.5 Stars. The net impact of these Star Rating changes is an increase of $83.0 million (+$0.30 pmpm) in estimated 2024 MA spending. As CMS mentioned in the proposed rule, this increase in MAO spending is due to plans more commonly performing more favorably on these measures.

- **Tukey Outlier Deletion**. Tukey outlier deletion removes data points that are deemed "outliers" from the data set before running the CMS clustering methodology. Because there are typically more low outliers than high outliers, this change would increase cut points and decrease measure-level Star ratings for many contracts.

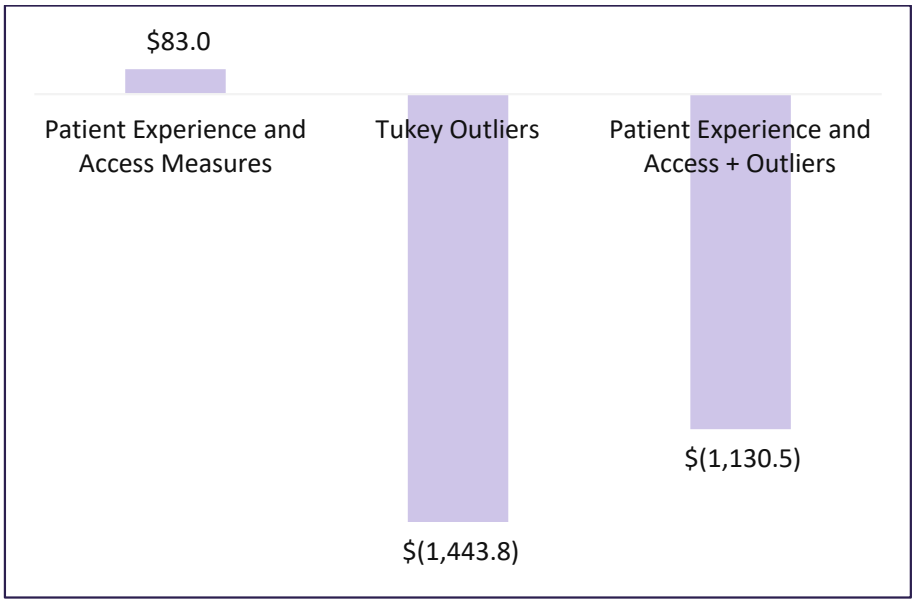
  If this change were implemented for the 2020 Star Ratings, without applying any other proposed 2021 and 2022 Star Rating changes, 3.3 percent of MA–PD contracts and 11.9 percent of members would have seen their Star Rating increase by half a star, while 18.7 percent of contracts and 17.3 percent of members would have decreased by half a star. The net impact of these Star Rating changes is a decrease of $1.4 billion (-$5.24 pmpm) in estimated 2024 MA spending.

Combined All 2023 Star Rating Proposed Changes.

The proposed Tukey outlier deletion change impacts various measures differently – specifically, this change would decrease non-CAHPS Star Ratings but would not have an impact on the CAHPS measures, many of which are also Patient Experience and Access measures. The result is an offsetting impact when these two changes are applied all together versus individually.

Figure 1 below shows the dollar impact that each Star Rating change is anticipated to have on MA spending, as well as the combined impact of both changes. Positive values indicate an increase in MA spending and additional costs for CMS. Negative values indicate a decrease in total MA Spending due to a particular Star Rating change, driving net savings for CMS.

Figure 1 – Proposed Rule Changes, Impact to MA Spending
Shown in millions

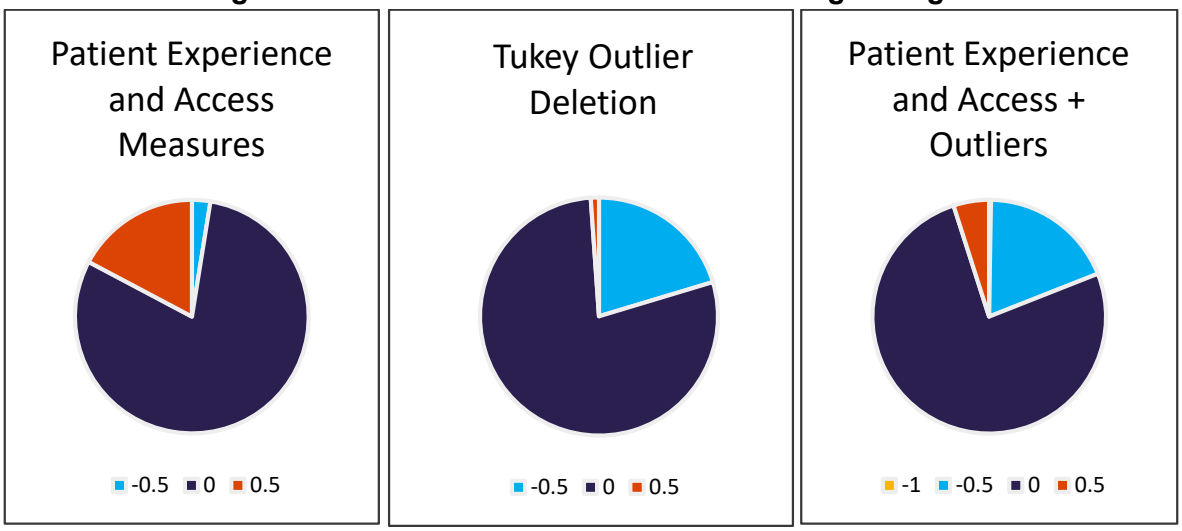


The combined impact of the Proposed Rule is a lower level of savings for CMS than if each change was evaluated separately. There is an offsetting impact between the change in cut-point methodology impacting all non-CAHPS measures and the increase in weight for Patient Experience and Access measures, many of which are CAHPS measures.

Figure 2 on the following page shows the distribution of contracts that improved 0.5 Stars, deteriorated by 0.5 Stars, deteriorated a full Star[8], or stayed constant (0) under each proposed Star Rating change.

[8] There was one contract that deteriorated a full star after the impact of both Patient Experience and Access Measures changing weight and Tukey Outliers being removed from the cutpoints.

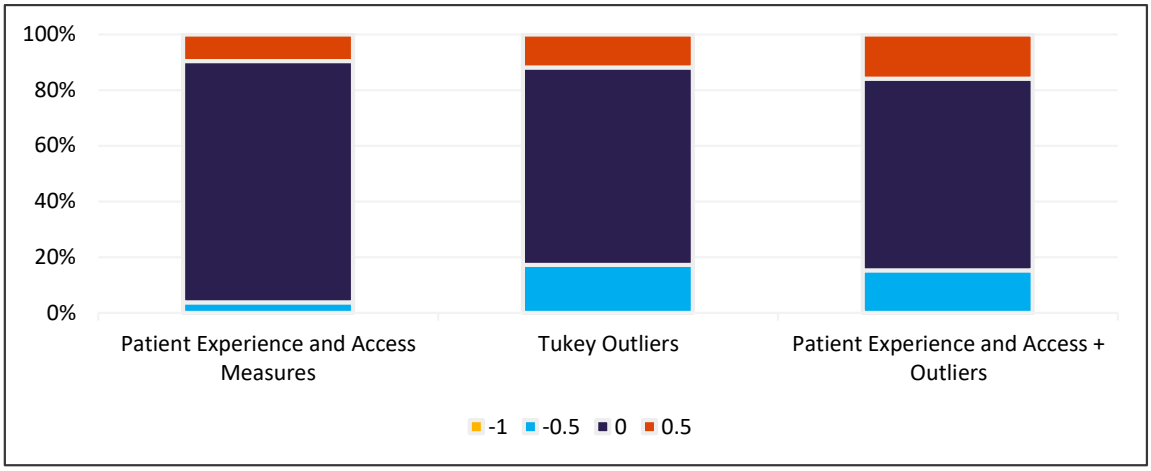
Figure 2 – Distribution of Contract Star Rating Changes



Note that the change in weighting for Patient Experience and Access Measures is favorable for more MAO contracts than it is unfavorable. On the other hand, almost a quarter of contracts will see a decrease in Star Ratings with the Tukey outlier change.

Figure 3 shows the distribution of members impacted by either an increase in half a star (0.5), a decrease in half a star (-0.5), a decrease in a full star (-1.0)[9], or members who were not impacted (0). Overall, between the two changes more members are expected to be impacted by a decrease in contract Star Rating than an increase.

Figure 3 – Distribution of Star Rating Changes, Member Weighted



[9] Although it is not visible in Figure 2 or Figure 3, one contract with just over 2,000 members decreases by a full star after considering the impact of the Patient Experience and Access Measures and Tukey outlier deletion changes.

Conclusion and Key Takeaways

Although the Wakely and CMS results differ due to known and unknown differences in methodology, our analysis suggests that the CMS quantification methodology may underestimate the negative impact of the Star Rating changes in the Proposed Rule.

CMS has not provided enough information on methodology and assumptions for other parties to independently validate or recreate the results.

There are several areas where CMS does not provide clarity on the methodology used to estimate the impact of these changes. In addition, CMS has estimated the impact of the proposed changes using an older data set (2018 Star Ratings), without updating for more recent MA plan sponsor performance in the Stars program. In order for stakeholders to fully understand and validate the impact to the Star Rating program, we respectfully request that CMS provide further documentation supporting the methodology for determining the published estimates in the Proposed Rule. In addition, we ask that CMS consider updating this analysis to use more recent Star Ratings data.

CMS estimates in the Proposed Rule may underestimate the negative impact on MA spending of proposed changes to the Star Ratings program, potentially significantly.

As illustrated throughout the report, the anticipated increase in MA plan sponsor spending driven by Patient Experience and Access measure changes is expected to be less than the CMS estimate, and the anticipated decrease in MA plan sponsor spending from the Tukey outlier deletion change is expected to be materially greater than the CMS estimate. In total, vs. the Wakely methodology, CMS may have understated the expected impact on MA plan sponsor spending in 2024 by more than $700 million.

Disclosures and Limitations

Responsible Actuary Suzanna-Grace Sayre and Dani Cronick are the actuaries responsible for this communication. They are both Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the sole use of the America's Health Insurance Plans (AHIP) and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. We acknowledge that AHIP may provide the report to their

participating health plans. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their actuarial experts in interpreting results. This information is confidential and proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this analysis are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. **Actual results may vary, potentially materially, from our estimates.** Wakely does not warrant or guarantee the projected values included in the analysis. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest We are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent to AHIP.

Data and Reliance We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Subsequent Events There are no known relevant events subsequent to the date of information received that would impact the results of this analysis. Differences or updates in the assumed contracts or risk and utilization of populations may cause deviation in results.

Deviations from ASOPS Wakely completed the analysis using sound actuarial practice. To the best of my knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations.

Appendix 1 – Finalized 2021 and 2022 Star Rating Changes

2021 Finalized Star Rating Program Changes

- Plan All Cause Readmission (Part C) to be temporarily removed while the measure is being updated
- All Patient Experience and Access Measures (Part C) to increase in weight from 1.5 to 2.0
- Recalculation of the Categorical Adjustment Index[10] (CAI) based on the latest plan performance data

2022 Finalized Star Rating Program Changes

- Adult BMI Assessment (Part C) to be removed
- Controlling Blood Pressure (Part C) to return to the Stars Calculation with a weight of 1.0
- Appeals Auto forward (Part D) to be removed – this is an Access measure that would have increased in weight for 2023 Star Ratings if it were not removed
- Appeals Upheld (Part D) to be removed – this is an Access measure that would have increased in weight for 2023 Star Ratings if it were not removed
- Cut point calculations to be updated with the additional process of mean resampling and adding 5% cut point guardrails

[10] The Categorical Adjustment Index is intended to adjust contract level Star Ratings based on level of Low Income and Disabled enrollment in the contract.

Appendix 2 – Methodology and Key Assumptions

Methodology Overview

Wakely used the published 2019 and 2020 Star Ratings Data Tables[11] to evaluate the impact that specific changes to the Medicare Star Rating Program and calculations would have to Medicare Advantage Organizations (MAOs). These tables include measure level data (ex. a contract scoring 83% on the Breast Cancer Screenings measure), measure level Star Ratings (ex. a contract receiving 4 stars out of 5 on the Breast Cancer Screenings measure), Part C and D cut points for each measure, and Overall Star Ratings. We then replicated the CMS calculations for the 2019 and 2020 Overall Star Ratings for every contract by calculating raw Overall Star Ratings (weighting each measure with the CMS defined measure weight) and then adjusting for Part C and D Improvement Measures, Reward Factors, and the Categorical Adjustment Index (CAI).

With all contracts aligning in their starting point – Calendar Year 2020 Overall Star Rating – each of the changes in the Proposed Rule could be evaluated separately as well as together.

Recalculating 2020 Star Rating Cut Points Using Public CMS Measure Data Sets

Wakely ran the clustering methodology on the published Star Rating measure data set to develop a new set of cut points for each Stars measure. Only the Stars measures that use clustering methodology were updated. All CAHPS measures use the relative distribution and significance testing methodology. There are no proposed changes to the relative distribution and significance testing methodology in the Proposed Rule, so Wakely used the published Star Ratings for these measures with no changes.

After developing a new set of cut points for each non-CAHPS measure, the results were then compared to the published 2019 and 2020 Star Rating cut points and checked for reasonability. For the majority of Stars measures, the new cut points were relatively unchanged from the publish cut points. However, there were several measures with large cut point differences: Diabetes Care – Kidney Disease Monitoring, Members Choosing to Leave the Plan, Timely Decisions and Appeals, Complaints About the Drug Plan, MPF Pricing Accuracy, and the Part C and Part D Health Plan Quality Improvement measures. Wakely used the published cut-points for these measures without any adjustments.

To estimate the impact of recalculating cut points using published data, Wakely recalculated the Overall Star Ratings for every available contract using the revised 2020 Star Rating cut points.

[11] https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData

Next, all contracts were identified with changing Star Ratings between the published cut points and the simulated Wakely cut points. 20 percent of contracts had an Overall Star Rating decrease by half a star. For these contracts, half a star was added in order to adjust the Wakely base 2020 Star Ratings to match the published Star Ratings. This adjustment was also made in each subsequent change to the Star Rating program. After making these adjustments, the resulting data set was normalized to remove the impact of using cut points recalculated from the published data set.

Mean Resampling and Guardrails

Wakely simulated the mean resampling and guardrail methods as described in the 2019 Final Rule to all of the non-CAHPS measures in the 2020 Star Ratings data set. The mean resampling and guardrail methods could have an effect not only on the current Star Ratings year but also on subsequent years. We accounted for this by simulating mean resampling on the 2019 Star Ratings data. The resulting cut points served as the reference point for applying the guardrail to the cut points obtained through applying both mean resampling and guardrails to the 2020 Star Ratings data. The 2020 Star Rating thresholds with mean resampling and a 5 percent guardrail were then simulated by referencing the simulated 2019 Star Rating cut points. The 5 percent guardrails were applied to all measures in the Part C and D Star Ratings program.

Patient Experience and Access Measures

In the 2021 Star Rating year, CMS will increase the weight of all Patient Experience and Complaints Measures as well as the weight of all Access Measures from 1.5 to 2.0. Under the Proposed Rule, CMS would again increase these weights further from 2.0 to 4.0 in the 2023 Star Rating year.

In order to calculate the impact of Proposed Rule change, Wakely recalculated the Overall Star Ratings for every available contract using the revised weights of 4.0. Note that the change currently being proposed and evaluated is a weight change from 2.0 to 4.0, since the change from 1.5 to 2.0 has already been codified. The changing weights also impacted the calculated reward factor for all contracts. Reward factors were recalculated to reflect the change in weights; however, the impact that these changing weights would have on the Part C and Part D Improvement Measure was not considered for this analysis.

Tukey Fence Outlier Exclusion

To improve stability in measure cut points over time, CMS has proposed to remove outliers using the Tukey Fence Outlier logic. This is a standard statistical method that identifies data points more than 3.0 times away from the outer quartiles. Values identified through Tukey outer fence

outlier deletion were then removed prior to mean resampling, and then clustering and the guardrails were applied.

To model this change, the clustering methodology was repeated after excluding any data-points identified as Tukey outliers and applying mean resampling. The change in cut points due to the outlier methodology was then applied to the current 2020 Star Rating cut points to establish new "Outlier" cut points, and guardrails were applied to limit the change between 2019 and 2020. Next, measure level data for all contracts and all non-CAHPS measures were compared to the cut points before and after the outlier exclusion and Overall Star Ratings were calculated.

One main simplification was made in this process. With the outlier changes, the Part C and Part D improvement measures would change based on changes to measure level Star Ratings. For this analysis, it was assumed that improvement measures would stay the same regardless of cut point changes.

Revenue Impact

The above methodologies describe how changes in Overall Star Ratings were determined for all contracts based on the CMS proposed changes. The last step in the analysis was to quantify the resulting financial impact of these changes. Table B1 demonstrates the impact that Star Ratings have on MAO plan benchmarks and rebate percentages.

Table B1: Quality Bonus and Rebate Percentages by Star Rating

Plan Rating	*Bonus Payment*	*Quality Bonus Adjusted Benchmark*	*Rebate Percentage*
5.0	*5.0%*	*105% of Benchmark*	*70%*
4.5	*5.0%*	*105% of Benchmark*	*70%*
4.0	*5.0%*	*105% of Benchmark*	*65%*
3.5	*0.0%*	*100% of Benchmark*	*65%*
3.0	*0.0%*	*100% of Benchmark*	*50%*
New Plans under New MAOs	*3.5%*	*103.5% of Benchmark*	*65%*
Plans Not Reporting	*0.0%*	*100% of Benchmark*	*50%*

To quantify this impact, first Individual county-level benchmarks for 2021 through 2024[12] were determined for every 2020 contract at each Star Rating from 1.0 to 5.0. This involved utilizing

[12] Contract level benchmarks beyond 2020 assumed a constant county level enrollment distribution from 2020 forward.

published February 2020 county-level enrollment and Wakely internal county benchmark projections based on the known quartile changes, ACA benchmark caps, and current CMS benchmark projections. A bid estimate was derived for each Star Rating by applying an estimated bid to benchmark ratio to the contract level benchmark. The bid to benchmark ratios was developed at the county, product, and SNP type-level based on historic publicly available bids and benchmarks and trends in bid to benchmark ratios by quartile. Using this established bid and benchmark, the resulting MA revenue was then determined for all individual plans at each Star Rating.

Because Employer Group Waiver Plans (EGWP) do not submit a bid, the revenue for these plans at each Star Rating was determined by the EGWP payment rate. The revenue impact of a change in Star Rating, therefore, is based on the change in the payment rates based on Star Ratings.

Finally, the quantified revenue impact was multiplied by the estimated contract risk score. Risk scores were developed from 2017 publicly available data at the county, product, and SNP type level and were applied to the contract based on their enrollment distribution at the county, product, and SNP type level.

TAB 9

PUBLIC SUBMISSION

As of: January 25, 2024
Received: April 06, 2020
Status: Posted
Posted: April 10, 2020
Tracking No. 1k4-9fz8-zk3n
Comments Due: April 06, 2020
Submission Type: Web

Docket: CMS-2020-0010
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2021 (CMS-4190-P)

Comment On: CMS-2020-0010-0002
Medicare and Medicaid Programs: Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Document: CMS-2020-0010-0510
Comment on CMS-2020-0010-0002

Submitter Information

Name: Lydia Wardi
Organization: Gateway Health Plan

General Comment

Attached are Gateway Health's comments on the CY 2021-2022 MA and Part D Proposed Rule.

Attachments

04-06-20 - Gateway Health Comments - CY 2021-2022 MA and Part D Proposed Rule

Four Gateway Center | 444 Liberty Avenue
Suite 2100 | Pittsburgh, PA 15222-1222

Gateway Health
I'm good with Gateway.

Seema Verma
Administrator Centers for Medicare and Medicaid Services,
U.S. Department of Health & Human Services,
Attention: Docket ID: CMS-2018-0154
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850

Re: Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (herein "CY 2021-2022 MA and Part D Proposed Rule.")

April 4, 2020

SUBMITTED ELECTRONCIALLY VIA
http://www.regulations.gov

Dear Administrator Verma:

On behalf of Gateway Health ("Gateway"), I am writing to you to offer comments on the CY 2021-2022 MA and Part D Proposed Rule.

Gateway is committed to improve the health and health care experience of the communities we serve. We thank the Department of Health and Human Services ("Department") for the opportunity to offer comments, and willingness to take these comments into consideration.

Gateway Comments - CY 2021-2022 MA and Part D Proposed Rule

II. Implementation of Certain Provisions of the Bipartisan Budget Act of 2018

- ***§ 422.102 Special Supplemental Benefits for the Chronically Ill (SSBCI)***
  - Gateway supports CMS' initiative of providing health plans with flexibility to help members suffering with chronic conditions. However, Gateway echoes an industry concern regarding the cost to administer such support, given the limited revenue streams to support plans in instituting these initiatives. Additionally, Gateway requests that CMS take into consideration

the potential for member confusion in the market place, as there may be a wide array of plan choices without a clear indication of which plan(s) have benefits tailored to chronic conditions.

- ***§ 422.514 Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes***
  - Gateway supports CMS' initiative of reviewing "D-SNP look-alike" MA plans, and would appreciate any insight from CMS regarding its rationale for the enrollment percentage in the definition of look-alikes for "80 percent or more duals purposes." Gateway requests that CMS consider an even lower percentage threshold, to help address the ongoing issues associated with "look-alike" MA plans. Additionally Gateway requests that CMS consider implementing an additional requirement for any low-premium non-DSNP plan design attracting duals (partial or full), to educate the members of D-SNP options available within their service area.

III. Implementation of Several Opioid Provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act

- ***§ 423.153 Eligibility for Medication Therapy Management Programs (MTMPs)***
  - Gateway believes that integrating ARBs into the existing MTM measure is a substantive change and would request that CMS consider temporarily retiring the associated Stars measure to allow plans to adjust strategies and capabilities.

V. Enhancements to the Part C and D Programs

- ***§ 422.3 Out-of-Network Telehealth at Plan Option***
  - Gateway would like to better understand the reason for the proposal to include non-contracted providers as eligible providers. Gateway believes there may be attendant risks in making non-contracted providers eligible, without the traditional quality safeguards established by in contracting and credentialing requirements. Gateway would also request that CMS consider potential member confusion in accessing non-contracted providers as eligible providers.

- ***§§ 422.162, 422.164, 422.166, 422.252, 423.182, 423.184, and 423.186 MA and Part D Prescription Drug Program Quality Rating System***
  - **Cut Point Guard Rails**
    - Gateway understands that CMS intends to implement a 5% guardrail on cut point movement. Due to outlier removal, it appears that cut point movement will likely be significantly higher than in previous years, and resultantly, plans could potentially be expected to make 5% improvements in multiple measures year over year until cut points stabilize. Given this potentiality, Gateway requests that CMS consider setting the guardrails closer to measure level targets to earn quality improvement (typically 2-3%). Gateway believes this would help to align cut point movement, and help to meet CMS's overall expectation of plan's year-over-year quality improvement.

- **Transitions of Care**
  - Gateway supports the proposed changes to TRC, but request that CMS consider retiring the MRP measure due to the duplication, and the fact that the TRC measure is a better indicator of the overall management of transition care for members who have been admitted. Gateway believes that these changes are substantive and will require an implementation period to operationalize the utilization of these new allowances.
- **CAHPs Weighting**
  - Gateway requests that CMS reconsider implementing this change in weighting as this highly subjective measure is likely to be biased by exigencies secondary to COVID-19.
- **Extreme and Uncontrollable Circumstances**
  - Gateway requests that CMS incorporate the insights gained from addressing COVID-19, and the impact that national and state emergencies will have on the Stars program, when finalizing its policy on extreme and uncontrollable circumstances.

VI. Codifying Existing Part C and D Program Policy

- ***§§ 417.416 and 422.116 MA and Cost Plan Network Adequacy***
  - Gateway appreciates CMS' initiative of expanding access to Telehealth for certain specialties and supports the continued initiatives. Further Gateway supports the expansion of allowing Telehealth services serve as a means for fulling network adequacy in rural service areas with limited specialties, and also supports the recommendation to lower the access percentage to 85% in those rural access points.
    Gateway would welcome CMS allowing plans to advance their Telehealth capabilities in all specialty types allowing for a continued innovation within the industry. Gateway would also like to understand how CMS will address Telehealth from a quality perspective and better understand which measures plans may be required to follow.

On behalf of Gateway, I thank you for considering these comments and am personally available if you should like to discuss them. Please feel free to contact me directly via office phone 412.690.7470 | lwardi@gatewayhealthplan.com

Sincerely,

Lydia Wardi
Senior Regulatory Affairs Analyst
Gateway Health

TAB 10

As of: January 25, 2024
Received: April 06, 2020
Status: Posted
Posted: April 10, 2020
Tracking No. 1k4-9fz8-8wz8
Comments Due: April 06, 2020
Submission Type: Web

PUBLIC SUBMISSION

Docket: CMS-2020-0010
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2021 (CMS-4190-P)

Comment On: CMS-2020-0010-0002
Medicare and Medicaid Programs: Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Document: CMS-2020-0010-0529
Comment on CMS-2020-0010-0002

Submitter Information

Name: Ginny Whitman
Organization: Alliance of Community Health Plans

General Comment

Please see the Alliance of Community Health Plans' comments on the proposed rule attached.

Attachments

ACHP Comment Letter - 2021 C-D Regulation (CMS-4190-P)

ACHP
ALLIANCE OF COMMUNITY HEALTH PLANS

April 6, 2020

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

Submitted via www.regulations.gov

Re: Medicare Program; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2021 and 2022 (CMS-4190-P)

Dear Administrator Verma:

The Alliance of Community Health Plans (ACHP) is pleased to submit comments in response to the proposed rule on Medicare Advantage and Part D.

ACHP is a national leadership organization bringing together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care. The non-profit, provider-aligned health plans that are ACHP members provide coverage in all lines of business for more than 22 million Americans across 35 states and the District of Columbia. ACHP members offer five of the fourteen 5-star rated Medicare Advantage (MA) plans.

We support the overall direction of this proposed rule, appreciating that CMS has reflected a number of ACHP's previous recommendations, and offer the following comments on the proposed rule:

Executive Summary of Comments

- ***Special Supplemental Benefits for Chronically Ill:*** ACHP urges CMS to consider certain extenuating circumstances where it is not appropriate for enrollees to file a grievance or appeal. We also request CMS allow for a one-year grace period during which a MA plan is not penalized (within reason) for potential issues that arise in the offering of a new, innovative SSBCI.

- ***ACHP supports CMS' proposal to increase the weight of patient experience/complaints and access to further emphasize their importance.*** However, we strongly encourage CMS to reconsider the leap in weight from 1.5 to 4. Currently, clinical outcome measures are weighted 3. Consumer experience is a high priority for ACHP members, yet we would not

support placing greater importance on sampled measures of experience than on measures of clinical effectiveness.

- ***End-Stage Renal Disease Proposals and Provisions:*** ACHP continues to strongly recommend that the Office of the Actuary analyze the impact of using smaller geographical areas such as Metropolitan Statistical Areas or counties as the basis for ESRD dialysis benchmark rates rather than statewide rates.

- ***Telehealth/Network Adequacy:*** ACHP strongly supports the proposed 10-percentage point credit for plans using telehealth to meet network adequacy requirements for certain providers and the proposed reduced threshold for determining time and distance standards in Micro, Rural and CEAC counties. ACHP requests that CMS also provide clarification regarding the network adequacy exception and customization process.

- ***MA and Part D Prescription Drug Plan Quality Rating System***: ACHP requests that CMS perform additional analysis of the Tukey cut point methodology so plans can project and compare impact on more than just the 2018 Star Ratings. While ACHP supports increasing the weight for patient experience measures, we request CMS consider a more gradual approach and adjust the weight to 3, the same as clinical outcome measures.

- ***Maximum Out-of-Pocket (MOOP) Limits for Parts A and B Services:*** ACHP opposes the addition of a third, intermediate MOOP. We are concerned that the addition of a third MOOP would not result in strong actuarial incentives for more MA plans to offer the lowest MOOP. ACHP offers several alternatives below.

- ***Second Preferred Specialty Tier:*** ACHP supports two Part D specialty tiers to encourage the use of biosimilars.

- ***Beneficiary Real Time Benefit Tool:*** ACHP supports requiring Part D sponsors to implement a real time benefit tool capable of providing beneficiaries with timely, clinically appropriate, patient-specific formulary and benefit information in a beneficiary-specific portal or computer application.

Part C Provisions

Implementation of Certain Provisions of the BBA 2018 — Special Supplemental Benefits for Chronically Ill (SSBCI)

ACHP appreciates CMS considering our recommendation to permit greater flexibility in defining a "chronically ill enrollee." This allows for plans to identify individuals with chronic conditions who may become eligible for SSBCI. ACHP supports CMS' proposal to publish a "non-exhaustive" list of chronic conditions that would qualify an individual for SSBCI. This proposal allows ACHP members to develop MA plan benefit designs that would provide SSBCI to individuals with one or more chronic conditions that are not on the list, provided they fall within the SSBCI definition

parameters. We strongly support this flexibility as our plans are best able to identify the enrollees suffering from chronic health conditions whose health could be most improved by SSBCI.

ACHP appreciates CMS' clarification regarding appeals and grievance procedure requirements for SSBCI but urges CMS to consider extenuating circumstances. ACHP maintains that the existing regulation is insufficient to address the unique circumstances of offering SSBCI. For example, a married couple may have the same MA plan but only one qualifies for SSBCI. The wife may receive different benefits and the husband, confused by this, wants to receive the same benefits. When the husband is told he is not eligible he may file an appeal or grievance. This is not an appropriate basis for an enrollee to seek redress through existing grievances and appeals when specifically related to SSBCI.

ACHP urges the administration to allow for a one-year grace period during which an MA plan is not penalized (within reason) for potential issues that arise in the offering of a new, innovative SSBCI. ACHP member plans are consistently looking for new benefits that will help their patient populations with chronic conditions and note that it can take time for all the "kinks" to be worked out. We encourage CMS to consider adding exceptions for circumstances such as the two above.

Improvements to Care Management Requirements for Special Needs Plans (SNPs)

ACHP supports CMS' proposal to apply the chronic condition special needs plan (C-SNP) enrollee management and model of care submission requirements to dual eligible SNPs (D-SNPs) and institutional SNPs (I-SNPs). ACHP recommends that CMS clarify that "providers" follows the definition of "provider" in 42 CFR § 422.2. We also recommend CMS provide additional details about what constitutes "demonstrated expertise and training."

Dual Eligible Special Needs Plan (D-SNP) Look-Alikes

ACHP supports CMS' proposed policies that establish regulatory requirements for D-SNP look-alikes to better ensure that all MA plans serving predominantly dual-eligible individuals provide coordinated and integrated Medicare and Medicaid services. ACHP also supports the proposal to limit the availability of D-SNP look-alike plans in any state where there is a D-SNP or any other plan authorized by CMS to exclusively enroll Medicaid beneficiaries. We applaud CMS's decision to not enter into or renew a contract for a MA plan that is not a MA SNP plan based on its actual or projected enrollment of dual eligibles.

ACHP also supports CMS' proposal to codify existing sub-regulatory guidance that prohibits Medicare Advantage organizations from marketing D-SNP look-alikes as if they were D-SNPs. We share CMS' concern that these practices are misleading and designed to confuse enrollees and suggest that the plan abides by standards and provides services that it does not.

End-Stage Renal Disease Proposals and Provisions (ESRD)

While ACHP supports the new enrollment flexibilities for individuals with ESRD, we continue to be concerned about the volatility of benchmark rates after the implementation of 21st Century Cures Act.

The ESRD population is a high cost population due to the use of expensive dialysis services and because this population often has other high cost comorbidities. In addition to dialysis, these beneficiaries are more likely to be hospitalized and use more physician and costly ancillary services. These costs vary significantly between urban and rural areas of a state. As a result, the overall ESRD health care costs in a MA plan's local service area are not likely to be accurately represented under the current statewide approach. This is particularly problematic for MA plans located in urban markets.

ACHP urges the Office of the Actuary (OACT) analyze the impact of using smaller geographical areas such as Metropolitan Statistical Areas (MSAs) or counties as the basis for ESRD dialysis benchmark rates rather than statewide rates. We believe that smaller geographic areas may be a more reasonable approach with growth of this population over time and the cost differences between urban and rural areas. This will better ensure greater accuracy in the acquisition costs that will be removed from ESRD rates and will improve the ability for MA plans to improve the contracts with their respective contracted dialysis provider.

ACHP encourages CMS consider other adjustments for ESRD rates to be developed for smaller geographical areas despite the problem of low case numbers. We understand that using statewide data in constructing these rates addresses the concern of there being too few cases in smaller geographic areas to be reliable. However, ACHP offers alternatives that could account for both low case numbers and region cost variations. For example, county rates could be adjusted using credibility factors. The ESRD county benchmark could, depending upon a credibility formula for the number of ESRD beneficiaries in a county, be the actual county data blended with the statewide data, using the statewide data as a manual rate. In some instances, the county benchmark could be strictly the manual rate of the statewide data for a county with no ESRD data credibility. Or the ESRD county benchmark could be the actual county cost and utilization data if the county ESRD data is deemed to be fully credible. This approach would be similar to the methodology CMS uses for MA Part C and D bids when the plan enrollment is too small to be credible. We encourage CMS to keep an open line of communication with MA plans as it is unclear how these proposals and considerations will factor into their plan bids.

ACHP supports all dialysis cost sharing to be equivalent to in-network rates. Due to the duopoly of providers nationally (85% of patients receiving dialysis from just two providers), MA plans have largely been unable to establish payment rates similar to traditional fee-for-service Medicare. In order to facilitate beneficiary protection and reduce total Medicare spending, we request CMS update section 50.1 of the MMCM Ch. 4 to require all dialysis cost-sharing to be equivalent to in-network and also section 110.1.3 to specify that MA plans must pay for dialysis treatment in all medically necessary cases, not just when temporarily absent from the plan's service area.

ACHP supports additional analysis of the ESRD rates to better understand the volatility of these rates and to make them more accurate and more predictable. We have seen volatility of the ESRD rates in recent years, making these rates difficult to forecast. One potential analysis would be to examine the impact of using 6 years of historical data for the Average Geographic Adjustment to reduce year-to-year volatility.

ACHP encourages CMS to consider creating an ESRD Payment Risk Corridor. As noted in our comments for the Medicare Advantage Advance Notice Part I and II for 2021, ACHP requests that CMS consider through its demonstration authority or other means to implement an ESRD payment demonstration such that the payments to plans are reconciled through a risk corridor-type program. ACHP is recommending a demonstration similar to the overall structure of the payment system in the Part D program. The ESRD population is a high-risk, high cost population in which the financial results of the overall MA plan can be greatly impacted because of a few very high cost cases. Both the size of the population that might move to MA as well as the health/selection risk are highly uncertain in 2021. One secondary impact could be many MA plans moving from the voluntary out-of-pocket maximum to the mandatory maximum out-of-pocket because of the increased enrollment of this high-risk population. In addition, the appropriate elimination of the organ transplant acquisition costs from ESRD payment rates poses timing difficulties for provider contracting.

ACHP would recommend the risk corridors be implemented for at least three years, similar to how corridors were first implemented in the Affordable Care Act for the uninsured population. If the risk corridor program is deemed successful in encouraging MA plans to enroll more ESRD membership, consideration can be given to widening the risk corridors over time.

We look forward to collaborating with CMS on designing this demonstration.

Lastly, ACHP recommends CMS develop standards and guidance for MA plans offering in-home dialysis. As a relatively new flexibility, MA plans are hesitant to move forward without additional guidance from CMS regarding quality and service standards. We encourage CMS to work with ACHP member plans and their quality experts in developing in-home care models.

<u>Telehealth/Network Adequacy</u>

ACHP strongly supports CMS' proposal to give a MA plan a 10-percentage point credit in meeting network adequacy thresholds when it contracts with telehealth providers in certain specialties. The 10-percentage point credit toward the percentage of beneficiaries meeting time and distance standards would be available when telehealth benefits are offered in the following specialty areas: dermatology, psychiatry, cardiology, neurology and otolaryngology. ACHP previously recommended that telehealth services be considered when determining fulfillment of network adequacy requirements. ACHP believes that the availability of the 10-percentage point credit will make a positive and significant impact for the ACHP member plans serving rural or network-sparse regions.

ACHP supports CMS' proposal to reduce the threshold for determining if a MA plan meets time and distance standards in Micro, Rural and CEAC counties. CMS' proposal to reduce the current

threshold that requires 90% of beneficiaries have access to at least one provider and facility of each specialty within the county to 85%of beneficiaries—in Micro, Rural and CEAC counties—is a positive first step in the evolution of time and distance standards.

ACHP members in rural communities often find that there is a more limited supply of physicians, specifically specialists, compared to in urban areas. Providers are more geographically disbursed, making the same time and distance standards that are applicable in metropolitan areas, problematic for smaller community-based plans. Quantitative standards that are overly strict in such areas give the few existing providers extraordinary bargaining power to raise prices. Plan sponsors required to meet those standards are therefore unable to negotiate better rates.

Lastly, ACHP would appreciate CMS clarifying the process for requesting Network Adequacy Customization and Exceptions. While the Medicare Advantage Network Adequacy Criteria Guidance document outlines the application process and permits exceptions to time and distance standards "when the healthcare market landscape has changed or does not reflect the current CMS network adequacy criteria," ACHP seeks examples of circumstances in which an exception would be appropriate.

ACHP also requests that CMS clearly delineate when it is appropriate for a plan to request a customization versus an exception, as the Medicare Advantage Network Adequacy Criteria document does not do so.

<u>Cost Sharing Flexibility</u>

ACHP supports CMS' proposed clarifications of a plan's ability to offer reduced cost-sharing. CMS proposes to codify that a MA plan can provide reduced cost-sharing for items and services that are not basic benefits—and that if a plan should provide those reduced cost sharing amounts, they may only be offered as mandatory supplemental benefits. In addition, CMS states that it would clarify that reduced cost sharing for basic benefits specifically relates to the value of Part A and B benefits. That text, however, does not appear in the proposed regulatory language. ACHP supports the proposal and encourages CMS to finalize such clarifications.

<u>Referral/Finder's Fee</u>

ACHP encourages CMS to consider increased transparency into broker payments and contracts. While ACHP is not opposed to eliminating unnecessary or duplicative regulations, we remain concerned about the lack of transparency into referral fees for agents and brokers. Currently brokers receive a stay-in fee for beneficiaries that remain enrolled in the plan and contract the broker previously facilitated. ACHP acknowledges that this was put in place to incentivize MA member retention. However, with approximately 98% of MA enrollees continuing to enroll in the program, this policy is outdated. In addition, this fee creates an unlevel playing field between ACHP members -- community based, nonprofits -- and their national competitors.

MA and Part D Prescription Drug Plan Quality Rating System (QRS)

ACHP appreciates CMS' efforts to refine the Quality Rating System to ensure that it continues to be a relevant tool that adequately and accurately measures and fosters high quality care and coverage. ACHP encourages CMS to use our member organizations as a resource in the evolution of the Quality Rating System. ACHP member plans have successfully delivered superior value through relationship-oriented practices focused on alignment of goals, payer-provider collaboration and appropriate financial incentives. We offer our assistance and expertise to CMS in developing measure concepts that flow from these best practices.

ACHP supports new methods to identify and remove outliers, but requests that CMS delay finalizing the Tukey methodology. ACHP agrees that this appears to produce more appropriate and accurate cut points provided that CMS test this methodology against more than just the 2018 Star Rating years. In addition, ACHP requests that CMS clarify the multiplier for the Tukey's fences calculation. In some definitions, ±1.5IQR is used to identify "outliers" while ±3.0IQR defines "far out" outliers. ACHP would welcome simulated data using previous years' data to help identify how mean resampling, guardrails, and now Tukey's fences will impact the Star Ratings playing field.

ACHP supports CMS' proposal to increase the weight of patient experience/complaints and access to further emphasize their importance. However, we strongly encourage CMS to reconsider the leap in weight from 1.5 to 4. Currently, clinical outcome measures are weighted 3. Consumer experience is a high priority for ACHP members, yet we would not support placing greater importance on sampled measures of experience than on measures of clinical effectiveness.

As an alternative, ACHP encourages CMS to increase the weight of patient experience/complaints and access to a 3. This places importance on member experience without diminishing the importance of clinical outcomes. It also maintains the integrity of the Triple Aim, in which all three of the components of quality, experience and cost are equally important.

ACHP members are dedicated to the closely aligned and integrated payer-provider model, and as a result are keenly aware of the tremendous impact the current COVID-19 pandemic is already having on quality measurement operations and performance. We urge CMS to consider the impact of triage and availability of services on all performance measures when making decisions about advancements in the QPS program this year. These changes are likely to have long-lasting effects for both providers and payers.

ACHP encourages CMS to implement a consistency measure for plans maintaining overall Star ratings of 4.5 for two or more years and reevaluate the use of outdated improvement measures. Measures of improvement can blur the distinction between high-scoring plans with consistently high performance and those with more opportunity for improvement. For some high-performing plans, the ability to improve upon a particular measure narrows simply because they can top out on performance. For lower performing plans, the ability for improvement is greater even though they are starting from a lower position. ACHP is concerned that some improvement measures are no longer achieving the desired intent of rewarding plans for improvement. ACHP believes that consistency and stability in performance over time should be rewarded equally. This would promote star ratings more appropriately based on performance across the entire range of clinical, patient experience and administrative/compliance measures.

ACHP supports CMS' efforts to eliminate topped out measures and reduce the number of measures overall. ACHP agrees with the Medicare Payment Advisory Commission that there has been a proliferation of measures which yield limited information to support clinical improvement or consumer decision-making, and that dilute quality measures results. For instance, MedPAC found that of the 376 MA contracts with Star Ratings in 2019, 71 contracts had administrative measures averaging 4.5 Stars or higher, but outcomes averaging less than 3.5 Stars. We encourage CMS to continue moving forward with eliminating topped out measures and reduce the number of measures overall. Without such efforts, too many measures, and process measures in particular, increase the documentation and reporting burden for plans and providers and provide little to no benefit to consumers.

Maximum Out-of-Pocket (MOOP) Limits for Parts A and B Services

ACHP opposes CMS' proposal to add a third, intermediate MOOP configuration at the numeric midpoint between the current mandatory and voluntary MOOP limits. We are concerned that the addition of a third MOOP would not result in strong actuarial incentives for more MA plans to offer the lowest MOOP — a benefit that best serves frail and high cost/high utilization enrollees. Further, the availability of three MOOPs raises complexity for enrollees. This proposal would make it more difficult for MA plans to determine which MOOP offers the best "value," and new and existing enrollees would face more confusing choices when selecting a plan.

ACHP thanks CMS for including our recommendation to add length of stay scenarios for acute and psychiatric care. ACHP supports CMS' proposal to add a 3-day length of stay scenario for acute stays and an 8-day length of stay scenario for psychiatric care. Next to physician visits, inpatient services have the highest Medicare utilization, and therefore the largest actuarial value. A larger actuarial value offers greater incentive for a plan to choose the voluntary MOOP.

We offer several alternative approaches to encourage more MA plans to offer the voluntary MOOP, many of which could be accomplished by CMS under existing regulatory authority or through its demonstration authority.

- Raise the voluntary MOOP to an amount that represents the 87th percentile of projected Original Medicare out-of-pocket costs instead of the existing 85th percentile, while retaining the existing 95th percentile for the mandatory MOOP. We believe that by moving the voluntary MOOP and mandatory MOOP amounts closer together it will incentivize plans to move to the voluntary MOOP. MA plan cost sharing has increased significantly over the last 10 to 15 years, yet the voluntary MOOP remained at $3,400 over that same time period, which contributed to pushing more plans to the mandatory MOOP limit. As MA plans increase their cost sharing over time, the voluntary MOOP limit should increase simultaneously. For CY 2022, CMS should consider increasing voluntary MOOP to reflect the 88th percentile, for example.

- Better differentiate the MOOP cost sharing values between voluntary and mandatory MOOP. We recommend that CMS better differentiate the maximum copays between the two

MOOPs for those service categories with high utilization. The two service categories with the highest Medicare utilization are: Primary Care Physician (7a) and Physician Specialist (7d). Currently, the maximum copays for these are the same under voluntary and mandatory MOOPs. 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). 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.

- Add new cost sharing limits for observation services and ambulance services and clearly differentiate the maximum copays for these services in the voluntary and mandatory MOOP copays.

- Vary the cost sharing limits for emergency care/post stabilization, home health services, and physician specialist services. We would recommend adding the service category—primary care physician (7a). Increasing the differential for emergency care / post stabilization is an important service category for increased copays. Increased copays on emergency room care incentivizes members to use the appropriate level of care, e.g., physician visits or urgent care, and not over utilize the higher cost ER services. Also, although we support home health service copay differentiation, it should be noted that home health services copay differentiation does not equate to much actuarial value given its low utilization. In addition, many plans do not impose home health copays primarily because it is difficult to collect copays, and many home health agencies are not set up to collect cost sharing under Medicare.

- We do not recommend any more differentiation in the nominal cost sharing limits for the first 20 days of a skilled nursing facility stay. The current differentiation between the copays is currently reasonable, and the utilization for this service is very low so there is not much of an actuarial value for a nominal copay of $10 or $20 per day on this service category, meaning it will not be much of an incentive for a plan to choose the voluntary MOOP.

- Give additional star credit rating value for a plan imposing the lower voluntary MOOP.

<u>Medicare Communications and Marketing Guidelines</u>

ACHP appreciates that CMS is codifying longstanding policies and guidance in its "*Medicare Communications and Marketing Guidelines.*" We encourage CMS to continue to provide policy interpretations of the market and communication guidelines, examples and best practices in their original format, in addition to codifying these policies. The guidelines are frequently used and read by individuals unfamiliar with regulatory and legal text. Retaining the format will reduce potential confusion and mistakes.

In response to CMS' request for comments on how to implement prohibitions related to health plan marketing during the open enrollment period, ACHP recommends that CMS provide specific examples of language that is and is not permitted.

Part D Provisions

Safe Disposal of Drugs

ACHP requests additional clarification on CMS' proposal that MA plans provide information on the safe disposal of prescription drugs when furnishing an in-home risk assessment, in both verbal and written communications. ACHP appreciates the guidance already provided on the steps needed to ensure that medications are safely disposed of and request additional clarification on whether or not the in-home risk assessment extends to outside locations where seniors reside, such as senior-living centers, nursing homes or assisted living facilities.

Eligibility for Medication Therapy Management (MTM) Programs

ACHP supports CMS' proposal to codify existing guidance permitting plans to identify their own criteria for whom to target for the MTM program. We encourage CMS to finalize the provision that would apply existing MTM program standards to at-risk beneficiaries under Section 6064 including that the enrollees must be automatically enrolled with an opt-out and that plan sponsors must offer an annual comprehensive medication review and targeted medication reviews no less than quarterly.

Permitting a Second "Preferred" Specialty Tier

ACHP supports CMS' proposal to permit a Part D plan to have up to two specialty tiers and to establish a maximum allowable cost sharing of 25 percent for plans with a full deductible and 33 percent for plans with no deductible applicable to the higher cost-sharing specialty tier. We agree that this additional flexibility could encourage a lower-cost specialty tier that includes and encourages the use of biosimilars. We expect that it could improve competition among specialty drugs and the ability of Part D sponsors to negotiate better prices with manufacturers and lower costs for beneficiaries. The addition of this second tier could generate plan savings if manufacturers start to offer rebates for specialty drugs on a preferred tier, similar to how preferred non-specialty brand drugs are administered today. Part D plans will likely save on drug ingredient costs as well.

ACHP would also support improving the incentives for plans and beneficiaries to realize greater savings when they need costly specialty treatment and we encourage CMS to study alternative catastrophic reinsurance models to incentivize the greatest savings for plans implementing a preferred specialty tier.

Beneficiary Real Time Benefit Tool (RTBT)

ACHP supports requiring Part D sponsors to implement a Real Time Benefits Tool (RTBT) capable of providing beneficiaries with timely, clinically appropriate, patient-specific

formulary and benefit information in a beneficiary-specific portal or computer application. This support is consistent with previous ACHP comments that encouraged CMS to finalize its 2019 proposal to provide more information on drug coverage and costs to clinicians at the point-of-prescribing through the use of a RTBT. At that time, we noted that prescribers as well as patients need access to three critical pieces of information: clinical appropriateness, coverage and cost. ACHP supports enhancing transparency within the pharmaceutical industry, including for patients and prescribers.

We anticipate that implementation of such a tool across Part D sponsors will not only help lower drug expenditures for the Medicare program, but also improve patient outcomes. Incorporating drug coverage and cost information, including a beneficiary's copayment or coinsurance, at the point of prescribing improves adherence. Beneficiaries may abandon their prescription when taking it to a pharmacy to be filled because they learn it is not covered or too expensive. Providing that information up front to enrollees can reduce such occurrences.

If finalized, ACHP recommends that CMS develop an optional, model tool for all health plans to use. A CMS-developed tool could reduce costs for health plans and help ensure consistent functionality across plans. While we acknowledge that some of the drug pricing information aligns for both the prescriber and beneficiary tools, we are concerned that CMS underestimates the amount of time and costs that are associated with implementing consumer-facing drug pricing tools, and recommend that the start time is delayed until Jan. 1, 2023.

ACHP supports CMS' proposal to allow Part D plans to offer rewards and incentives to encourage consumer use of the real-time benefits tools. ACHP member plans with experience in online price transparency tools report that offering rewards and incentives can build utilization and engagement. ACHP generally supports the $15 per login ($75 in the aggregate annually) cap proposed and suggests CMS implement similar discrimination bans as those required by Medicare Advantage Prescription Drug plans.

<u>Pharmacy Performance Measure Reporting Requirements</u>

ACHP supports CMS' proposal to begin to explore the use of Pharmacy Performance Measures by requiring Part D sponsors to disclose to CMS the measures they use to evaluate pharmacy performance. We agree that additional analysis in this area is important to better understand the growth in the use of financial penalties and other price concessions and the public reporting of those measures can contribute to increasing transparency.

ACHP also encourages CMS to explore the development of consensus pharmacy performance measures for a future Part D Star Ratings program that would assess Part D plan sponsors' uptake of a standard set of pharmacy performance measures or that evaluate the percent of high-performing pharmacies in the sponsors' network.

We strongly recommend, however, that CMS develop these efforts with stakeholders that can contribute based on experience and expertise. CMS should build on best practices of high-quality plans such as ACHP members. Our member plans are community-based, non-profits that have successfully delivered better value through relationship-oriented practices focused on alignment

of goals, health plan and provider collaboration and appropriate financial incentives. We offer our assistance and expertise to CMS in developing pharmacy measure concepts that flow naturally from these best practices and deliver greater value.

Conclusion

Thank you for your consideration of ACHP's comments and recommendations for the Contract Year 2021 and 2022 Medicare Advantage and Part D Proposed Rule. ACHP appreciates the Administrations' continued efforts to improve and refine the MA program. We welcome continued engagement on our member plan best practices and efforts to offer evidence based, high quality and consumer focused MA and Part D plans.

If you have questions or require additional information, please contact Michael Bagel (mbagel@achp.org), ACHP Director of Public Policy.

Sincerely,

Ceci Connolly
President and CEO
Alliance of Community Health Plans

TAB 11

PUBLIC SUBMISSION

As of: March 04, 2024
Received: February 09, 2023
Status: Posted
Posted: February 13, 2023
Tracking No. ldx-oa8f-c3is
Comments Due: February 13, 2023
Submission Type: Web

Docket: CMS-2022-0191
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024

Comment On: CMS-2022-0191-0001
Medicare Program: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, etc.

Document: CMS-2022-0191-0315
Comment on CMS-2022-0191-0001

Submitter Information

Email: dan.elling@fhpstrategies.com
Organization: SCAN Health Plan

General Comment

See attached file(s)

Attachments

2.9.23 Final SCAN Health Plan CY 2024 MA and Part D Policy and Technical Changes Comment Letter

3800 Kilroy Airport Way
Suite 100, P.O. Box 22616
Long Beach, CA 90801-5616

TEL 562.989.5100
FAX 562.989.5200

VIA ELECTRONIC SUBMISSION: http://regulations.gov/

February 13, 2023

The Honorable Xavier Becerra
Secretary, Department of Health & Human Services (HHS)

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services (CMS)
Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: SCAN Health Plan Comments on CMS-4201-P

Dear Secretary Becerra and Administrator Brooks-LaSure:

SCAN Health Plan (SCAN) is pleased to submit comments in response to the ***Contract Year 2024 Policy and Technical Changes to the Medicare Advantage (MA) and Medicare Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications.*** We applaud the Administration for its leadership in developing policies that improve the healthcare of Medicare beneficiaries, including those who are vulnerable and have complex conditions, and especially appreciate your focus on health equity.

The following includes background on SCAN and comments on selected provisions in the proposed rule.

I. SCAN Background

SCAN Health Plan, one of the nation's foremost not-for-profit MA plans, serves over 270,000 members in California. SCAN Desert Health Plan and SCAN Health Plan also provide MA coverage to people in Arizona, Nevada, and Texas. Independence at Home, a SCAN community service, provides vitally needed services and support to seniors and their caregivers regardless of plan membership. SCAN is proud to have earned a 4.5-star rating from CMS in each of the last six years and named one of the best insurance companies for MA in California by *U.S. News and World Report* for the fifth straight year.

II. SCAN Comments on Selected Provisions

Implementation of Certain Provisions of the Bipartisan Budget Act of 2018, the Consolidated Appropriations Act, 2021, and the Inflation Reduction Act of 2022

Applying D-SNP Look-Alike Requirements to Plan Benefit Package Segments *(§§422.503(e), 422.510 and 422.514),* p. 79465

- **CMS Proposal:** CMS proposes to extend its ban on Dual Eligible Special Needs Plans (D-SNP) "look-alikes" to the segment level in specified situations and to add regulatory language that would provide the agency with the authority to sever the D-SNP look-alike from the MA plan and permit termination of an MA contract when an MA organization meets the criteria for a D-SNP look-alike plan. Rather than continue the current standard based on actual enrollment, CMS proposes to identify an MA plan as a D-SNP look-alike if it projects dual enrollment of at least 80% in its bids or has actual enrollment that exceeds the regulatory threshold.

- **SCAN Comments:** SCAN requests greater clarity regarding CMS' authority to terminate a contract. SCAN opposes terminating an entire H contract number if CMS is to determine that a Plan Benefit Package (PBP) of a health plan is a D-SNP look-alike due to a duals membership enrollment rate greater than 80%. In addition, the proposed rule does not specify whether the proposed standards would apply to Chronic Condition Special Needs Plans (C-SNPs). SCAN asks that the final rule provide more detail and transparency regarding the application of this proposal.

Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Behavioral Health in Medicare Advantage (MA) *(§§422.112, 422.113, and 422.116)*, p. 79488

- **CMS Proposal:** CMS proposes to codify the appointment wait time standards for primary care and behavioral health services that are described in Chapter 4 of the Medicare Managed Care Manual. This would require immediate provision of urgently needed or emergency services, the provision of services that are not urgent but that require medical attention within one week, and the provision of routine and preventive care within 30 days.

- **SCAN Comments:** While SCAN believes that establishing consistency between primary care and behavioral health is a great step towards recognizing the need for behavioral health standards, the proposed appointment wait time standards will do little to address the overarching problem of access to care for two reasons. First, the well-documented behavioral health provider shortage will make this standard immensely difficult to comply with. Health Resources and Services Administration (HRSA) projects that the

supply of adult psychiatrists will decrease by as much as 20% by 2030[1], with rural areas experiencing the greatest burden[2]. Little can be done about appointment wait times when the workforce is not large enough to improve the rate at which patients are seen. Second, this standard puts the onus on health plans and does little to incentivize providers to take measures that would increase the availability of their care. The most effective way for health plans to play a role in improving network adequacy would be to increase reimbursement rates, which would in turn incentivize providers to take the necessary measures to decrease behavioral health appointment wait times. Increased reimbursement rates may also improve the behavioral health workforce shortage issue.

Request for Comment on the Rewards and Incentives Program Regulations for Part C Enrollees *(§§ 422.134 and Subpart V)*, p. 79508

- **CMS Proposal:** CMS solicits comments on whether the agency should further define "cash equivalent" and whether CMS should revise MA rewards and incentives program regulation to include parameters for the permissible offering of gift cards as MA reward items.

- **SCAN Response:** SCAN agrees that further definition is needed from CMS relative to what "can and cannot" be included. If there are to be guidelines, we propose to limit the amount (e.g., not greater than X dollars) in addition to limiting the use of the reward to direct health related expenses only.

Review of Medical Necessity Decisions by a Physician or Other Health Care Professional with Expertise in the Field of Medicine Appropriate to the Requested Service and Technical Correction to Effectuation Requirements for Standard Payment Reconsiderations *(§§ 422.566, 422.590, and 422.629)*. p. 79509

- **CMS Proposal:** CMS proposes to require that the MA organization determination for a partially or fully adverse medical necessity decision be reviewed by a licensed physician or other appropriate healthcare professional with expertise in the field of medicine or health that are appropriate for the service at issue. The reviewing healthcare professional would not need to be of the same specialty or subspecialty as the treating healthcare provider. Plans would have the discretion to determine what constitutes appropriate expertise on a case-by-case basis.

- **SCAN Response:** SCAN supports CMS' proposal to not require the case reviewer to be trained in the exact specialty of the service at issue. Given the nationwide shortage of primary care physicians, SCAN asks that CMS include registered nurses, clinical psychologists, and pharmacists as appropriate reviewers in the final rule.

[1] Health Resources and Services Administration. (2022). *Behavioral Health Workforce Projections. Retrieved from https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health*

[2] Association of American Medical Colleges. (2022). *A growing psychiatrist shortage and an enormous demand for mental health services.* Retrieved from https://www.aamc.org/news-insights/growing-psychiatrist-shortage-enormous-demand-mental-health-services

Effect of Change of Ownership Without Novation Agreement *(§§ 422.550 and 423.551)*, p.79511

- **CMS Proposal:** CMS seeks to revise §§ 422.550(d)(1) and 423.551(e)(1) to clarify that the agency may terminate a contract if the owner has been acquired but no novation agreement is signed. CMS also makes it clear that in this case that the affected contract may be unilaterally terminated by CMS which establishes that failure to comply with the regulatory requirements contained in part 422 (or part 423 if applicable) is a basis for CMS to terminate an MA or Part D contract. Additionally, CMS proposes to amend the regulations at §§ 422.550(d) and 423.551(e) to impose applicable sanctions before terminating a contract that has a change in ownership without a novation agreement, in accordance with CMS requirements and provides an opportunity for organizations to demonstrate that the legal entity that is assuming ownership by way of novation would be able to meet the requirements set forth by CMS regulation. Lastly, this proposal imposes intermediate enrollment and marketing sanctions on the affected contract, which would remain in place until CMS approves the Change of Ownership, or the contract is terminated.

- **SCAN Response:** While SCAN supports CMS' novation agreement standards, we ask that CMS consider the following recommendations. First, we believe that it would be inappropriate for CMS to terminate a contract if the standards are not met. We suggest that CMS render a less significant penalty, such as issuing a fine to the new owner when a novation agreement is not filed in the specified circumstances. Fully terminating the H contract would not be in the best interest of MA beneficiaries who are enrolled in that H number. However, a fine would not disrupt the impacted beneficiaries' coverage.

  Second, CMS should make an exception to the proposed penalties for changes of ownership under the same parent organization. This exception is supported by other exceptions CMS makes for transactions that occur under the same parent organization (e.g., exception to the prohibition on first dollar percent reinsurance and the exception to the requirement that changes of ownership must include the transferor's entire MA line of business).

  Third, given the long lag in CMS's application cycle (i.e., the notice of intent to apply is due in November, followed by application due in February, and approved application/contract is not effective until the subsequent January); the imposition of intermediate sanctions until an application and novation are approved will have a devastating and long-term impact on the affected contract and parent organization. This long lag in the application cycle often causes MA changes of ownership to not go forward and is not in the best interest of the program or beneficiaries, particularly when the transferor MA organization is struggling financially or otherwise. SCAN recommends that CMS either not impose intermediate sanctions or impose them for a shorter period. Lastly, SCAN asks that CMS clarify what constitutes a change of ownership requiring a novation.

Updating Translation Standards for Required Materials and Content *(§§ 422.2267 and 423.2267)*, p.79521

- **CMS Proposal:** CMS proposes to require MA organizations to provide materials to enrollees in any non-English language that is the primary language of at least five percent of the individuals in a PBP service area and in any accessible formats upon receiving a request for the materials in another language or learning of the need for an accessible format using auxiliary aids and services. CMS also proposes to extend its translation requirements to SNP enrollee individualized plans of care.

- **SCAN Response:** SCAN already conforms to these standards today. However, CMS should clarify that the proposed translation standards apply only to required materials, such as member information materials (e.g., Evidence of Coverage), and do not apply to supplemental documents, such as health education materials.

Medicare Advantage (MA) and Part D Marketing *(Subpart V of Parts 422 and 423)*, p.79524

- **CMS Proposal:** CMS proposes to codify guidance prohibiting personal marketing appointments from taking place until after 48 hours have passed since the time the scope of appointment was completed by the beneficiary and removes "when practicable" language.

- **SCAN Response:** SCAN believes that removing the "when practicable" language would eliminate scenarios that would prevent a beneficiary from enrolling for the next month effective if said scenario was within two days of end of month. This change would not improve beneficiaries' ability to gain coverage as most plans experience high enrollment numbers within the last few days of each month.

Part D Medication Therapy Management (MTM) Program *(§§ 423.153(d))*, p.79542

- **CMS Proposal:** CMS proposes changes to the enrollee targeting and eligibility criteria, including requiring plan sponsors to target all core chronic diseases and HIV/AIDS; lowering the maximum number of covered Part D drugs a sponsor may require from eight to five; and revising methodology for calculating the cost threshold to be commensurate the average annual cost of five generic drugs. In addition, CMS proposes guidance and clarification regarding the comprehensive medical review.

- **SCAN Response:** SCAN supports CMS in its effort to make Medication Therapy Management the cornerstone of the Part D program. We encourage CMS to consider any revisions to the MTM program beginning 1/1/2025 due to implications to healthcare costs that must be finalized for bid submissions and operational enhancements to be appropriately implemented in time. CMS has the opportunity to improve MTM due to the introduction of three new measures in Stars focusing on medications (polypharmacy) into the program. The proposed changes to criteria will expand eligibility but do not tackle providing MTM to Medicare beneficiaries who could truly benefit from it.

SCAN opposes the modifications to the cost threshold and recommends that CMS seek insight from the industry, such as the Pharmacy Quality Alliance (PQA), on how best to adjust the threshold(s) so that the appropriate members are eligible for the program. As leaders in older adult care, we do not shy away from CMS holding us to higher health outcome standards and would welcome the opportunity to work together so that MTM is more than just a means through which to earn a Star Rating. SCAN firmly believes in the value of pharmacists, MTM programs, and targeted expansion of the MTM program to close gaps and ensure appropriateness of drug therapy for those who could benefit. The current proposed changes merely expand the criteria on who to provide the program to and would over capture individuals that would not reap the benefit versus the cost of the service.

Medicare Advantage/ Part C and Part D Prescription Drug Plan Quality Rating System

Measure Weights *(§§ 422.166(e) and 423.186(e))*, p.79623

- **CMS Proposal:** CMS proposes to lower the weight of patient experience/complaints and access measures from 4 to 2 beginning with the 2026 Star Ratings.

- **SCAN Response:** SCAN is supportive of CMS's proposal to reduce the weighting of access related measures to 2.

Health Equity Index Reward *(§§ 422.166(f)(3) and 423.186(f)(3))*, p.79626

- **CMS Proposal:** CMS proposes to replace the current reward factor with a new health equity index (HEI) in Part C and D Star Ratings, which would reward contracts for obtaining high measure-level scores for the subset of enrollees with three specified social risk factors (SRFs), beginning with the 2027 Star Ratings.

- **SCAN Response:** We applaud CMS' ongoing work to advance health equity. SCAN has doubled down on its efforts to close inequity gaps amongst diverse populations including duals, non-dual Latinx and African American populations, and LGBTQ+ individuals as we passionately believe in improving health outcomes for these populations. However, SCAN has some concerns with CMS' proposed HEI reward methodology.

  First, CMS should provide a more detailed HEI methodology. It is unclear whether CMS would consider the three specified SRFs as independent factors and thus calculate the HEI score with them separately or if they would be combined in a manner similar to the calculation of the Categorical Adjustment Index. It is also unclear whether the weights of selected measures would be used when calculating the final HEI. In addition, SCAN recommends that CMS include SRFs such as the Social Vulnerability Index (SVI) and race/ethnicity in their calculation of HEI given the significant impact that these factors have on health outcomes.

Second, we are concerned that CMS is proposing to replace the current reward factor with the new HEI reward. The premise of the current reward factor is to reward contracts for high and consistent performance. This is complementary and not contradictory to the proposed HEI; thus, we recommend that CMS combine the current reward factor with the HEI proposed in this proposed rule. One possible way is to keep the current reward factor for rewards of 0-0.2 on the proposed non-tiered scale and consider HEI for rewards amounting to 0.3-0.4.

Third, SCAN recommends that the implementation of the HEI begin with a subset of measures, such as HEDIS measures, and gradually factor in all other measures over time. This would allow plans to adjust to the new index and likely result in more significant outcomes.

Fourth, SCAN is concerned that the proposed HEI reward methodology eliminates the reward factor contracts that have percentages of enrollees with any of the specified SRFs less than the contract-level median. This is particularly troubling for contracts located in California because the state requires Dual Eligible Special Needs Plans (D-SNPs) to create separate contracts. This will result in contracts with significantly less dual-eligible and disabled members and eliminate the contract's opportunity to receive the HEI reward.

Fifth, SCAN asks CMS to model the effect of HEI prior to implementation using the next two years' data and sharing them as display measures. In addition, we recommend that CMS provide methodology details and simulation results at the contract level.

Finally, SCAN supports a multi-year journey to improve outcomes and eliminate inequities through the improvement factor that is focused on this particular population versus the reward factor being used only on the basis of this population. This would help in continuous quality improvement not only for these diverse populations, but also other populations. SCAN serves many Latinx and African American members who are non-duals and non-LIS and still experience inequities. Based on the CMS proposal, these populations will be left behind.

Improvement Measure Hold Harmless *(§§ 422.166(g)(1) and 423.186(g)(1))*, p.79632

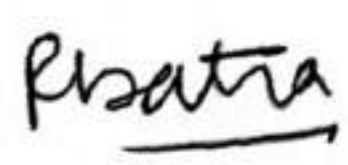
- **CMS Proposal:** CMS proposes to modify the improvement measure hold harmless provision to limit its application to contracts with 5 stars beginning with the 2026 Star Ratings.

- **SCAN Response:** SCAN respectfully requests that CMS keep the hold harmless measure as it currently stands. Many high performing contracts would be negatively affected by the proposed change as it is very challenging to achieve statistically significant thresholds. For example, there are situations in which the statistically significant threshold is over 100%, which is impossible to achieve.

Contracts with a star rating of 4 or 4.5 have higher proportions of individual measures rated at 5 stars, ranging from 42% to 55% of the measures among MA-PD plans as reported in the proposed rule. If a plan consistently receives a 5-star rating for a set of measures, these measures are less likely to be positively contributing to the net improvement (numerator of the improvement measure scores) since they are likely to have already hit a ceiling. This means that improvement scores will be dependent on a much smaller set of measures if the proposed rule is finalized. At the same time, these attainment measures still count toward eligible improvement (denominator of the improvement measure scores). As a result, 4 or 4.5 star contracts that perform consistently well in many measures already are likely to be negatively impacted. Therefore, we urge CMS not to modify existing improvement measure hold harmless provision.

Thank you for the opportunity to submit comments on this proposed rule. SCAN truly appreciates your commitment to improving the health of older adults and vulnerable populations. Please do not hesitate to contact me at RBatra@scanhealthplan.com, if you would like additional information.

Sincerely,



Romilla Batra, MD, MBA
Chief Medical Officer
SCAN Health Plan

TAB 12

As of: March 04, 2024
Received: February 13, 2023
Status: Posted
Posted: February 17, 2023
Category: Association - Other
Tracking No. le3-aj9d-tvul
Comments Due: February 13, 2023
Submission Type: API

PUBLIC SUBMISSION

Docket: CMS-2022-0191
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024

Comment On: CMS-2022-0191-0001
Medicare Program: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, etc.

Document: CMS-2022-0191-0674
Comment on CMS-2022-0191-0001

Submitter Information

Email: kconnor@ahip.org
Organization: AHIP

General Comment

Please see attached AHIP comment.

Attachments

AHIP_Comments_CY2024 MA Proposed Rule 2.13.23

Guiding Greater Health

601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
C 202.450.8218
ahip.org

Matthew Eyles
President & Chief Executive Officer

February 13, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services (CMS)
Attention: CMS-4201-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications ("Proposed Rule")

Dear Administrator Brooks-LaSure:

Americans agree: The Medicare Advantage (MA) and Part D programs are enormously successful models of public/private partnerships that offer choice, competition, and innovation in their coverage and care. These programs deliver high-quality, affordable coverage and care to tens of millions of America's seniors and people with disabilities. AHIP[1] welcomes the opportunity to comment on the Proposed Rule, which would have significant impacts on these programs.

More than 30 million Americans have chosen MA – almost half of those eligible for Medicare. MA plans deliver better services, better access to care, and better value than the original Medicare program. Enrollees in MA are more racially and ethnically diverse and are more satisfied with their coverage than those in original Medicare. MA also enjoys strong bipartisan support.[2] And more than 50 million enrollees are receiving robust access to prescription drugs through Part D plans.[3] Despite exorbitant launch prices for new drugs and out-of-control drug price increases on existing medicines, Part D plans have kept premiums steady by negotiating lower costs with drug manufacturers and pharmacies, using available, tested and effective cost management and negotiating tools.

[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.
[2] See, e.g., the recent letter to CMS from a bipartisan group of more than 60 Senators.
[3] More than 27 million receive their Part D coverage through MA plans.

To build on these successes, AHIP supports a number of proposals that would strengthen consumer protections while retaining flexibility, choice, competition, and value. **At the same time, we are concerned that certain proposals would reduce funding or increase costs without benefiting seniors and people with disabilities.** Further, the sweeping changes under consideration here, when combined with recent statutory changes and other payment and regulatory changes either finalized or proposed elsewhere, will increase financial and operational uncertainties and create new barriers to the continued availability of high-value, affordable coverage. Accordingly, **we urge CMS to consider how the combined impacts of these numerous changes could inhibit innovation, increase confusion and complexity, and ultimately harm seniors and people with disabilities**. We also urge CMS to consider regulatory approaches that will ensure stability and value for the tens of millions of people these programs serve. The following is a summary of key areas of support and concern, with more information in our attached detailed comments.

Key Proposals We Support Include:

- **New Marketing Requirements That Would Protect Medicare-Eligible Americans Without Unduly Burdening Access to Help in Choosing Medicare Options.** AHIP appreciates CMS' efforts to enhance federal requirements designed to protect Medicare-eligible Americans from misleading advertising, and to reduce confusion and abrasion. AHIP supports many of CMS' proposals to add new marketing standards and oversight requirements to the robust rules already in place. However, as discussed in our attached detailed comments, CMS should reconsider how certain proposals such as mandated waiting periods for meetings with trusted agents and brokers could unduly inconvenience seniors and people with disabilities who face social barriers, mobility challenges, or rely on trusted family members or caregivers who have limited availability to participate in multiple sessions with the Medicare-eligible person. In addition, we believe certain proposals require longer implementation timelines than CMS has proposed given the need for additional CMS guidance, revised materials and/or updated training.

- **New Prior Authorization Standards That Clarify MA Flexibilities Without Unduly Limiting the Ability to Promote High Value Care.** We appreciate that CMS recognizes utilization management tools like prior authorization (PA) are an important means to coordinate care, reduce inappropriate utilization, and promote cost-efficient care. Numerous studies have found Americans frequently receive inappropriate care in a variety of settings for many different medical procedures, tests, and treatments.[4] PA can ensure care is delivered in the most appropriate setting, at the most appropriate frequency, and by the most appropriate provider. At the same time, health insurance providers have been working hard to

[4] The Institute of Medicine has confirmed that geographic variations in spending are substantial, pervasive, and persistent over time and there is little to no correlation between spending and health care quality. In a national survey of over 2,000 physicians, most (64.7%) reported at least 15-30% of medical care is unnecessary.

make PA more efficient, more effective, and less burdensome.[5] We support CMS proposals that build on these efforts by clarifying the scope of permissible PA, increasing transparency, and (in a separate proposed rule) expanding electronic PA. However, in our detailed comments we urge CMS to retain long-permitted flexibilities in the MA program so plans can encourage the delivery of high-quality care in safe, cost-effective alternative settings that are covered in the original Medicare program. We also are concerned about the feasibility of implementing new restrictions and process mandates for 2024 given MA bid cycle and operational needs.

- **Provisions That Would Promote Health Equity.** AHIP continues to strongly support CMS' efforts to advance health equity. We support provisions in the Proposed Rule such as enhancing digital health literacy and using quality improvement program activities to reduce disparities in health and health care. We also support CMS' efforts to develop a health equity index reward in the Star Ratings Program but have concerns with methodological and design issues in the index proposed by CMS. Additionally, we recommend that CMS improve enrollee data collection and align data collection standards across programs.

Key Areas of Concern Include:

- **Star Ratings Program Changes That Would Not Increase Quality but Would Reduce Benefits or Increase Premiums.** We have serious concerns with proposed changes to the Star Ratings program, including proposals to eliminate the reward factor and limit application of the hold harmless policy for the improvement measures, which would make it more difficult for MA plans to obtain funds to offer more choices, expand supplemental benefits, and keep premiums low. We are also concerned that implementation of Inflation Reduction Act (IRA) changes in Part D could further negatively affect certain Star Ratings measures and plan performance due to factors outside of plan control. While we appreciate CMS proposing to decrease the weight of survey measures relative to the weight of clinical outcome measures as AHIP has previously recommended,[6] the overall impact of the Star Ratings proposals would be higher premiums and/or reduced benefits for enrollees, impacts that would disproportionately affect seniors and people with disabilities in underserved communities without increasing quality.

[5] In July 2022, AHIP posted a comprehensive report on how health insurance providers have delivered on their commitments to improve PA for patients and providers. This report follows up on the 2018 Consensus Statement among providers, health insurers, and other stakeholders recommending opportunities to improve the PA process.
[6] At the same time, we encourage CMS to review separate comments that AHIP members may submit on this topic so the agency more fully appreciates the investments MA plans have made to improve patient experience and their perspectives on the potential implications of the proposed change. We also urge CMS to continue working with the Agency for Health Research and Quality (AHRQ) and National Committee for Quality Assurance (NCQA) to research longer-term solutions to improve the CAHPS survey and response rates.

- **New Network Requirements That Would Fail to Account for Provider Shortages and Related Factors.** Every day, health insurance providers work with people, providers, and communities to ensure access to mental health care and support through methods such as coordinating and integrating mental health with medical and physical health care, expanding access to telehealth appointments, and reducing the stigma associated with mental health conditions. We also recognize that with more Americans of all ages seeking mental health care, capacity is being stretched to its limits. AHIP and our member organizations have developed specific policy recommendations to improve access, care, and equity for patients.[7] Certain CMS proposals build on these efforts - such as promoting continuity of care for behavioral health services through MA care coordination programs. However, we have significant concerns that proposals to apply new time and distance standards to three behavioral health specialty types and to impose appointment wait time mandates for behavioral health and primary care fail to appropriately account for provider shortages and other factors outside plan control. A more flexible approach is needed to accommodate these reasonable factors and avoid placing unreasonable expectations or burdens on providers.

- **Proposed Changes to Part D Medication Therapy Management (MTM) Program Requirements That Would Be Costly and Disruptive**. Given major changes to Part D taking affect under the IRA, CMS should not be mandating a rapid increase in staffing and administrative structure to implement proposed expanded eligibility criteria for MTM programs. Before any such changes are made, additional analysis is needed to assess the effectiveness of the MTM program and alternative methods already being used by plans and contracted providers. However, if the proposal is finalized, we urge that changes be phased in over time.

Overall Concerns with Magnitude of Proposed Changes Affecting MA. In addition to our comments on the specific provisions in the Proposed Rule, it is important to consider them on a combined basis and in the context of a broader set of policy changes affecting the MA program.

- **Taken together, CMS in one plan year is making (or proposing to make) sweeping changes affecting critical components of the MA program without a comprehensive assessment of the combined impacts of those measures.** The sheer magnitude of changes in the Proposed Rule is extensive, with major proposals affecting key MA elements including utilization management, marketing, and Star Ratings. At the same time, there are other major changes outside the Proposed Rule affecting the MA program: the recently issued final Risk Adjustment Data Validation rule; the significant proposed changes in the interoperability rule that will affect the MA program; and proposed major changes relating to the risk adjustment model and other payment components in the 2024 Advance Notice.

[7] https://www.ahip.org/resources/a-vision-for-improved-mental-health-care-access-for-every-american.

- **We are concerned that CMS has not considered how provisions applying similar approaches to different policy objectives could adversely affect enrollees.** For example, the Proposed Rule would expand situations in which MA plans must proactively conduct outreach to members after a primary care or mental health provider leaves a network. This change should not be considered in a vacuum; adding more outreach to the robust proactive communications that MA plans already conduct (e.g., care coordination activities, claims/appeals processes, etc.) creates the risk that seniors and people with disabilities come to view the combined impacts of these contacts as overly aggressive and intrusive rather than helpful.

- **The changes are taking place while plans are working to implement the biggest changes to the Part D program since its inception due to the recently enacted IRA.** Changes in Part D can have significant impacts on MA organizations, including increasing the cost of providing Part D coverage as supplemental benefits, and focusing organizational time and resources on comprehensive implementation efforts.

- **These provisions are on top of the numerous changes that have been made to the MA and Part D programs in prior years**, some of which are now being undone under the Proposed Rule. It means MA plans are required to devote significant resources each year to implementation, training, provider contracting, communications, and other actions – resources that could otherwise be used to provide additional benefits to enrollees.

The cumulative impact of those factors is significant. They create tremendous uncertainty that inhibits planning and investments in long-term innovations. These changes impose higher administrative costs due to factors outside of plan control. Compliance is more challenging when systems and training requirements must be constantly updated, particularly when paired with extremely short implementation deadlines that fail to reflect MA and Part D bidding cycles and operational and contracting needs. The accumulated changes also create more confusion and complexity for enrollees, family members, agent/brokers, and providers. **Ultimately, all these factors combine to increase program costs, limit choice, reduce supplemental benefits, and/or increase premiums.**

As the MA program continues to grow, we urge CMS to account for how so much uncertainty and change can undermine the ability of MA plans to continue offering innovative, affordable options to seniors and people with disabilities. We recommend that CMS seriously consider options to bring more stability to the program by limiting the number and scope of changes, extending implementation timelines, and other approaches. We look forward to discussing those strategies with CMS.

The Value of Medicare Advantage

MA delivers better services, better access to care, and better value through innovative, patient-centered programs that improve quality and reduce costs for seniors and the most vulnerable Americans with disabilities.

Care for diverse and vulnerable populations. Medicare Advantage plans care for a growing share of Medicare beneficiaries dually eligible for Medicare and Medicaid benefits. In 2019, 44% of dual-eligible beneficiaries were enrolled in MA, up from 25% in 2013[8], and research shows dual-eligibles enrolled in MA have greater health needs than those in original Medicare.[9] MA also serves a more racially and ethnically diverse population. In 2020, 30% of MA enrollees were minorities, compared with 20% of those in original Medicare.[10] Minority populations are especially prevalent among those who choose MA plans that combine both medical and prescription drug coverage with monthly premium beyond the standard Part B premium.[11]

In 2020, over half of all racial and ethnic minorities were enrolled in MA, up dramatically from 2006, when only about a third of minorities chose MA.[12] Recent research shows MA plans have made substantial progress in reducing health disparities for racial and ethnic minorities and rural populations across key health measures such as getting an annual flu vaccine, diabetic eye and kidney exams, and access to preventive and ambulatory services.[13]

Greater care coordination and more comprehensive benefits. MA plans work with their members to prevent, detect, and manage chronic conditions through programs that better integrate and coordinate care compared to original Medicare. MA plans also provide more comprehensive benefits than original Medicare. Some of these essential benefits include integrated dental, hearing, and vision coverage along with innovative telehealth options. In recent years, MA plans began offering new types of benefits that address various social barriers to better health, such as wellness programs and nutrition, transportation, and in-home caregiver services, and the availability of these benefits has grown tremendously. In 2022, 1,034 plans offer a new type of health-related benefit designed to help support enrollees such as in-home support services, home-based palliative care, adult day services, or caregiver support, and

[8] Murphy-Barron, C, Pyenson, B, Ferro, C, et. al. “Comparing the Demographics of Enrollees in Medicare Advantage and Fee-For-Service Medicare.” Milliman. October 2020.
[9] NORC at the University of Chicago. “Analysis of COVID-19 Impact on Medicare Advantage and Fee-for-Service Beneficiaries.” May 2021.
[10] AHIP. “Medicare Advantage Demographics Report.” January 2023.
[11] NORC analysis of June 2021 CMS Medicare enrollment and demographic data, conducted for AHIP. December 2021.
[12] Trish, E, Valdez, S, et. al. "Substantial Growth In Medicare Advantage And Implications For Reform.” Health Affairs. 42. No 2 (2023): 246-251.
[13] RAND Health Care. “Trends in Racial, Ethnic, Sex, and Rural-Urban Inequities in Health Care in Medicare Advantage: 2009-2018.” December 2021.

increase of 111% since the benefits were first made available in 2020.[14] The availability of special supplemental benefits for chronically ill Americans – benefits like nutrition support, transportation for non-medical needs, or structural home modifications to support independent living – have grown even faster, increasing by almost 400% to more than 1200 plans in 2022.[15]

More financial security. All MA plans deliver affordable coverage to members by capping annual out-of-pocket costs while individuals with original Medicare coverage alone are exposed to extraordinarily high cost-sharing. MA premiums continue to decline, falling 8% from 2022 to an average of $18 a month in 2023.[16] Further, the Medicare Payment Advisory Commission (MedPAC) reports that in 2023, 99% of those eligible for Medicare have an option to enroll in a MA plan that offers drug coverage for no additional cost.[17]

Better health outcomes. MA has been shown to provide better quality of care on various clinical quality measures[18], reduce hospital admissions and readmissions as well as patient days spent in rehabilitation facilities and nursing homes[19,20,21], and lower hospital use in the last days of life.[22] Peer-reviewed research has found that MA plans outperform original Medicare across a range of metrics, including better access to preventive care and better clinical outcomes.[23] For example, MA enrollees are more likely to receive important preventive services like annual wellness exams and cognitive screenings than their counterparts in original Medicare.[24]

---

[14] ATI Advisory. "New, Non-Medical Supplemental Benefits in Medicare Advantage in 2022." January 2022. Accessed at https://atiadvisory.com/wp-content/uploads/2022/01/Plan-Year-2022-Medicare-Advantage-New-Non-Medical-Supplemental-Benefits.pdf.
[15] Id.
[16] CMS. CMS Releases 2022 Premiums and Cost-Sharing Information for Medicare Advantage and Prescription Drug Plans. September 2021. Accessed at https://www.cms.gov/newsroom/press-releases/cms-releases-2023-premiums-and-cost-sharing-information-medicare-advantage-and-prescription-drug.
[17] Medicare Payment Advisory Commission. "The Medicare Advantage Program: Status report and mandated report on dual-eligible special needs plans." January 2023 Public Meeting.
[18] Agarwal, R., Connolly, J., Gupta, S., et al. Comparing Medicare Advantage And Traditional Medicare: A Systematic Review. *Health Affairs* 40(6): 937-944. June 2021.
[19] Kumar, A., Rahman, M., Trivedi, Amal, N. et al. Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data. *PLoSMed* 15(6): e1002592.
[20] Jung D., DuGoff E., Smith M., Palta M., Gilmore-Bykovskyi A., Mullahy J. Likelihood of hospital readmission in Medicare Advantage and Fee-For-Service within same hospital. *Health Serv Res*. 2020;55:587–595.
[21] Schwartz, A., Slaoui, K., Foreman, R., et al. Health Care Utilization and Spending in Medicare Advantage vs. Traditional Medicare: A difference-in-difference analysis. Jama Health Forum. 2021.
[22] Sungchul, P., Teno, J., White, L., Coe, N. Effects of Medicare advantage on patterns of end-of-life care among Medicare decedents. Health Serv Res. February 13, 2022.
[23] DuGoff, E., Rabak, R., Diduch, T., et al. Quality, Health, and Spending in Medicare Advantage and Traditional Medicare. *The American Journal of Managed Care* 27(9). September 2021.
[24] Jacobson, M., Thunell, J., and Zissimopoulos, J. Cognitive Assessment at Medicare's Annual Wellness Visit in Fee-For-Service and Medicare Advantage Plans. *Health Affairs* 39 (11): 1935–1942. November 2020.

Research also suggests that MA does a better job in addressing complex care needs than original Medicare. In one cross-sectional study of 1.8 million Medicare beneficiaries, those enrolled in MA had lower rates of hospital stays, ED visits, and 30-day readmissions. Overall, the study found that among Medicare beneficiaries with complex care needs, those enrolled in MA had lower rates of acute care utilization, suggesting that managed care activities in MA may influence the nature and quality of care provided to these beneficiaries.[25]

Studies have also found better outcomes for patients with specific chronic diseases when they are covered by MA. When compared to patients with original Medicare, MA members with end stage renal disease have lower mortality and reduced utilization.[26] Further, MA members with diabetes and cardiac disease experienced fewer emergency room visits and hospitalizations and better quality scores compared with those covered under original Medicare.[27] Lastly, MA members who experience a hip fracture have shorter lengths of stay and fewer hospital readmissions.[28]

Cost efficiency for seniors and taxpayers. For many years, average MA plan bids for delivering the basic Medicare benefit have been well below original Medicare costs — 83% of original Medicare, based on the latest MedPAC estimates.[29] Research provides examples of how MA plans achieve these savings: for example, through more efficient prescribing of Part B drugs and MA enrollees receiving care from more efficient providers.[30] Further, according to MedPAC, average payments to MA plans in 2023 are projected to be on par with original Medicare costs while MA offers supplemental benefits and enhanced financial security for seniors.[31] In fact, in areas where MA enrollment is higher relative to original Medicare, additional MA enrollment leads to slower original Medicare costs and spending growth as

[25] Antol, D., Schwartz, R., Caplan, A., Casebeer, A., Erwin, J., Shrank, W., Powers, B. Comparison of Health Care Utilization by Medicare Advantage and Traditional Medicare Beneficiaries with Complex Care Needs. JAMA Health Forum. 2022.
[26] Powers, B., Yan, J., Jingsan, et al. The Beneficial Effects of Medicare Advantage Special Needs Plans for Patients with End-Stage Renal Disease. *Health Affairs* 39(9): 1486–1494. September 2020.
[27] Landon, B., Zaslavsky, A., Saunders, R., et al. A comparison of relative resource use and quality in Medicare Advantage health plans versus traditional Medicare. *American Journal of Managed Care* 21(8): 559-566. August 2015.
[28] Kumar, A., Rahman, M., Trivedi, Amal N. et al. Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data. *PLoSMed* 15(6): e1002592. June 2018.
[29] Medicare Payment Advisory Commission. January 2023 Public Meeting Presentation. January 2023.
[30] Anderson, K., Polsky, D., Dy, S., et. al. Prescribing of low-versus high-cost Part B drugs in Medicare Advantage and traditional Medicare. *Health Serv Res.* 2021.
[31] Medicare Payment Advisory Commission. January 2023 Public Meeting Presentation. January 2023.

providers employ MA practice patterns and care guidelines for their remaining original Medicare patients.[32,33,34,35]

Leading the way in value-based care. MA plans are leading the way in leveraging value-based payment arrangements, working with providers to bring better quality and more affordable care to patients. In 2021, more than half (58%) of health care payments from MA plans were tied to alternative payment models in 2020, compared to 47% in original Medicare and 40% overall.[36]And research shows that these alternative payment arrangements mean MA patients get higher value care. One recent study found that those enrolled in MA received 9.2% fewer low-value services than those in original Medicare. The MA enrollees in health maintenance organizations and those in primary care organizations reimbursed within advanced value-based payment models had the lowest rates of low-value care.[37] Another study showed MA plan value-based payment arrangements with providers resulted in lower costs, improved patterns of utilization, and higher survival rates.[38]

High satisfaction. A recent survey finds continued high satisfaction with the MA program with 94% of senior voters with MA reporting satisfaction with their health care coverage. A strong majority of senior voters with MA are satisfied with access (95%) and affordability (90%) of medical care through their MA coverage. Among rural voters with MA, nearly all (96%) are satisfied with access of medical care through their MA coverage. Nine in ten voters with MA are satisfied with their prescription drug coverage (90%, including 60% very satisfied) and preventive services they receive (92%, including 64% very satisfied). Nine in ten (93%) voters with MA would recommend their coverage to their families or friends based on their personal experience.[39]

---

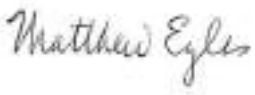
[32] Johnson, G., Figuero, J., Zhou, X., et al. Recent growth in Medicare Advantage enrollment associated with decreased fee-for-service spending in certain US counties. *Health Affairs* 35(9): 1707-1715. September 2016.
[33] Callison, K. Medicare managed care spillovers and treatment intensity. *Health Economics* 25(7):873-887. July 2016.
[34] Baicker, K., Robbins, J. Medicare payments and system-level health-care use: The spillover effects of Medicare managed care. *American Journal of Health Economics* 1(4):399-431. October 2015.
[35] Baicker, K., Chernew, M., Robbins, J. The spillover effects of Medicare managed care: Medicare Advantage and hospital utilization. *Journal of Health Economics* 32(6):1289-1300. December 2013.
[36] Health Care Payment Learning & Action Network. APM Measurement: Progress of Alternative Payment Models. November 2022. Available at: https://hcp-lan.org/apm-measurement-effort/2022-apm/.
[37] Boudreau, E., Schwartz R., Schwartz, A., Navathe A., Caplan, A., et.al. Comparison of Low-Value Services Among Medicare Advantage and Traditional Medicare Beneficiaries. *JAMA Health Forum.* 2022;3(9):e222935. doi:10.1001/jamahealthforum.2022.2935.
[38] Mandal, A. Tagomori, G., Felix, Randell V. et al. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. *American Journal of Managed Care* 23(2): e41-e49. February 2017.
[39] Morning Consult National Poll. December 6-9, 2022. Available online at: https://medicarechoices.org/americans-like-ma-2023/.

Seniors and the most vulnerable Americans with disabilities deserve to know they can count on the essential benefits and affordable, high-quality coverage they need to stay healthy. That's why more than 30 million Americans – some 46% of all those eligible for Medicare – choose MA – with a recent study in *JAMA Health Forum* finding that more Americans are switching to MA plans from original Medicare.[40]

Conclusion

Again, we appreciate the opportunity to comment on the Proposed Rule and your continued commitment to partner with MA and Part D plans. Attached are detailed comments on the foregoing proposals and other provisions in the Proposed Rule. Our recommended changes are designed to maintain and grow strong and stable MA and Part D programs so the millions of seniors and people with disabilities who rely on them continue to receive the high-quality, coordinated care they deserve. We look forward to continuing to work together on policies that ensure affordable and innovative choices in MA and Part D to improve the health and well-being of Americans.

Sincerely,



Matthew Eyles
President & Chief Executive Officer

[40] Unuigbe, A., Cintina, I., Koenig, L. Beneficiary Switching Between Traditional Medicare and Medicare Advantage Between 2016 and 2020. *JAMA Health Forum.*3(12):e224896. December 29, 2022.

AHIP Detailed Comments
Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

General comment on effective date for new requirements

The MA and Part D Proposed Rule for CY 2024 codifies a number of existing provisions of MA and Part D guidance and adds a significant number of new requirements. It appears that the new provisions are generally effective for 2024 with some exceptions (e.g., certain Star Ratings proposals).

Discussion and Recommendations:

Given the volume and complexity of the changes proposed to take effect for CY 2024, CMS should provide MA plans with more time to implement the new requirements included in the Proposed Rule. By the time this rule is finalized, plans may have only several weeks to fully assess all of the changes to existing program requirements, adequately reflect these changes in their 2024 bids, modify contracts, and make systems and other operational changes needed to meet the 2024 effective date. **We therefore urge CMS to delay the effective date to 2025 or later for new regulatory requirements that are finalized under this rule and are not required by statute or existing rules to take effect by 2024, including but not limited to:**

- **Proposed changes to MA plan use of utilization management (UM) policies and tools.** Given the volume and complexity of the expansive set of proposed changes, as discussed in more detail below, we urge CMS to delay until 2026 the effective date of new regulatory requirements focused on UM that are finalized under this rule. A 2026 effective date would also align with CMS' proposed 2026 effective date for its Advancing Interoperability and Improving PA proposed rule[41] that also impacts MA plans.

- **Changes to Part D Medication Therapy Management (MTM) program requirements.** For reasons we detail in our comments below, AHIP recommends CMS not proceed with implementing the proposed MTM Program eligibility requirements. However, if CMS decides to proceed with expanding enrollment in the program in a final rule, we urge it to be done via a gradual/phased-in approach that allows plan sponsors sufficient time to adapt and scale up to better accommodate these new requirements. AHIP believes that—at a minimum—this approach is less disruptive (and costly) to enrollees, the Medicare program, and plans than simply adopting these changes as proposed and increasing enrollments by 64% in less than a year. These additional burdens would also be imposed at the same time as

[41] 87 FR 76238, December 13, 2022.

program changes imposed by the Inflation Reduction Act (IRA) provisions and other significant CMS policy changes are being implemented into Medicare.

- **Changes to the MA network standards and provider directories**. We recommend CMS delay the requirement for the addition of the proposed new directory data elements until solutions like CMS' National Directory of Healthcare Providers & Services (NDH) are further explored and implemented to address the inherent challenges of provider directories. We also recommend CMS provide plans more time, up to CY 2025, to meet the new network adequacy requirements for behavioral health (BH) services. Workforce shortages and other factors outside plan control should also be addressed through a modified network adequacy exceptions process.

- **Changes to the marketing requirements that rely on issuance of sub-regulatory guidance in advance of 2023 annual enrollment period (AEP).** Given the breadth and scope of the proposed changes to the marketing rules, we are concerned that by the time the final rule and sub-regulatory guidance are released, plans and their partners may not have sufficient lead time to implement all of the finalized marketing related changes impacting the AEP for CY 2024. We recommend CMS consider a 2025 effective date to ensure successful implementation.

II. Implementation of Certain Provisions of the Bipartisan Budget Act of 2018, the Consolidated Appropriations Act, 2021, and the Inflation Reduction Act of 2022

A. Applying D-SNP Look-Alike Requirements to Plan Benefit Package Segments (§§ 422.503(e), 422.504, 422.510 and 422.514)

CMS proposes to extend its regulatory prohibition on dual-eligible special needs plan (D-SNP) "look-alikes" to the segment level in cases where an MA plan benefit package (PBP) includes multiple segments with different benefit designs. In a conforming change, CMS proposes to provide itself with authority to sever the D-SNP "look-alike" segment from the related MA plan, which would allow the remaining segments of that MA plan to continue (along with any other MA plans offered under the same contract).

CMS proposes to identify existing MA plans as D-SNP "look-alikes" if they either project dual enrollment of at least 80% in their bids or have actual enrollment that exceeds the same regulatory threshold. Currently, the standard for existing plans is based only on actual enrollment. CMS specifies that the change would take effect for 2024.

Finally, CMS proposes to add regulatory language that would expressly permit termination of an MA contract when the contract meets the criteria for a D-SNP "look-alike" plan.

Discussion and Recommendations:

While AHIP has raised concerns in the past with the "look-alike" policy, the proposal to apply it to plan segments that meet the test for D-SNP "look-alike" plans would be a logical extension of such policy, and we appreciate the conforming change to allow remaining segments of the plan and other plans under the same contract to continue.

We also reiterate our prior concerns about the policy's failure to distinguish between full-benefit and partial-benefit dual eligibles for purposes of identifying D-SNP "look-alike" plans. While we understand the concern of CMS and states that "look-alike" plans may result in the diversion of full-benefit dual eligibles from integrated D-SNPs, partial-benefit dual eligibles are not eligible for Medicaid benefits (except for coverage of Medicare cost sharing) and cannot benefit from integrated D-SNPs to the same extent as full-benefit dual eligibles. Moreover, partial dual eligibles can benefit from the tailored care management approaches used by many MA plans and the supplemental benefits that MA plans can offer, especially special supplemental benefits for the chronically ill (SSBCI). **Therefore, we continue to urge CMS to reconsider the practice of including of partial dual eligibles in calculating the 80% threshold for "look-alike" plans.**

Regarding the proposed authority for CMS to terminate a MA contract that includes a plan that meets the criteria for a "look-alike" plan, we urge CMS to provide details regarding the circumstances under which it would use that authority instead of taking more incremental measures to achieve compliance with the "look-alike" policy.

Another issue noted by some of our members is that confusion can arise when crosswalk transactions are processed between segmented and non-segmented plans due to the variety of permissible scenarios. We understand that in some cases, crosswalk transition plans for 2023 were approved by CMS but MA plans later experienced incorrect denials during the plan crosswalk process despite the prior approval. **With respect to crosswalking, we recommend the agency provide full details of requirements and status of approvals in the CMS Health Plan Management System (HPMS).**

B. Part D Special Enrollment Period Change Based on CAA Medicare Enrollment Changes (§ 423.38)

CMS proposes to align the timeframe for use of the Part D special enrollment period (SEP) based on new Medicare Part B general enrollment period (GEP) enrollment effective date parameters stemming from the Medicare enrollment statutory changes made by the Consolidated Appropriations Act, 2021(CAA).

Discussion and Recommendations:

We support CMS' proposal to align the timeframe for use of the Part D SEP based on new Medicare Part B GEP enrollment effective date parameters.

C. Alignment of Part C and Part D Special Enrollment Periods with Medicare Exceptional Condition Enrollment (§§ 422.62 and 423.38)

CMS proposes to add corresponding exceptional condition SEPs for MA and Part D enrollment to align with the Medicare enrollment statutory changes made by the CAA. Therefore, individuals who use an exceptional condition SEP to enroll in premium Part A and/or Part B would be provided an opportunity to enroll in a MA or Part D plan, provided that the individual meets applicable eligibility requirements for the plan.

Discussion and Recommendations:

We support CMS' proposal to align the Part C and Part D SEPs with the Medicare exceptional condition enrollment.

III. Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

A. Health Equity in Medicare Advantage (MA) (§§ 422.111, 422.112, and 422.152)

CMS proposes the following changes for CY 2024 to support the advancement of health equity in MA:

- Equitable access – Current regulations require that MA coordinated care plans ensure that covered services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. CMS proposes to specify additional populations to whom this requirement would apply.

- Improvements to provider directories – CMS proposes to add two new required data elements to MA provider directories: providers' cultural and linguistic capabilities (including American Sign Language (ASL)) and notations for providers waived to treat patients with medications for opioid use disorder (MOUD).

- Digital health education – CMS would require MA plans to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy to assist with accessing any medically necessary covered telehealth benefits. Plans would also be required to make information about their programs available to CMS upon request.

- Change to quality improvement program requirements – CMS would require MA plans to incorporate one or more activities into their overall Quality Improvement Programs that help to reduce disparities in health and health care among their enrollees.

Discussion and Recommendations:

AHIP and our members strongly support the promotion of culturally competent care and equitable access to services for Medicare enrollees. We believe that everyone deserves affordable, high-quality health coverage and care. AHIP members have taken action to reduce disparities by addressing social drivers of health. Evidence shows that these solutions are working. For example, studies have found reduced health disparities for racial and ethnic minorities and rural populations served by MA plans across several key health measures, such as annual flu vaccines, diabetic eye and kidney exams, and access to preventive services.[42] MA plans are also increasingly using expanded regulatory flexibility to offer more benefits, including non-medical services and supports, to enrollees in need to help address social drivers of health and advance health equity. Research demonstrates that services and interventions that address the health-related social needs of MA beneficiaries can result in improved quality of life, improved health outcomes, and reductions in unnecessary health care utilization.[43]

In general, we support CMS' proposals to advance health equity. We ask CMS to ensure that the program requirements take into account data collection and other challenges that must be overcome for plans to identify individuals and populations facing health disparities and subsequently initiate activities and strategies to reduce such disparities. For example, some of the categories of underserved populations discussed under the agency's equitable access proposal are not clearly defined (e.g., religious minorities, areas with high levels of deprivation, people otherwise adversely affected by persistent poverty or inequality) or may present challenges to MA organizations with respect to beneficiary sensitivities around health plan collection of self-reported data (e.g., gender identity and sexual orientation). We therefore request that CMS consider the following comments and recommendations related to the health equity proposals:

- Equitable Access – To ensure that services are provided in a culturally competent manner and enrollees have equitable access to services under the Medicare fee-for services (FFS) and MA programs, we recommend that CMS take the following additional steps:

    + Improve data standards. Robust, accurate, actionable, and standardized demographic data is fundamental to advancing health equity. Current data content standards (whether from Office of Management and Budget, CMS, 2020 Census, or the 2011 Department of Health

[42] RAND Health Care. "Trends in Racial, Ethnic, Sex, and Rural-Urban Inequities in Health Care in Medicare Advantage: 2009-2018." December 2021.
[43] Innovative-Approaches-to-Addressing-SDOH-for-MA-Beneficiaries-FINAL.pdf (bettermedicarealliance.org); SDOH-MA-IssueBrief-2021.pdf (ahip.org).

and Human Services' recommendations proposed in the Affordable Care Act), unfortunately continue to lead to varied, inaccurate, incomplete, or missing data, with significant percentages of respondents selecting "Other" because current data response options often do not align with how people identify themselves. To improve upon existing demographic data standards, AHIP convened diverse groups of health insurance providers and other stakeholders (e.g., patients representing different communities, providers, community-based organizations, and others) for over 18 months from 2020 to 2022 in a Health Equity Workgroup and employed an evidence-based and stakeholder-driven process to develop improved data standards[44] using culturally appropriate framing that align with how people identify themselves. We are encouraged by the updated draft standards published by the Office of Management and Budget (OMB) on January 27, 2023, and we will be submitting comments.[45] **We welcome the opportunity to continue to discuss our recommended demographic data standards[46] in more detail with CMS.**

+ Improve data collection. Data collection through enrollment forms continues to be a critical part of efforts to address health equity and social drivers of health. **We recommend CMS propose further changes to the Medicare FFS and MA enrollment forms to enable collection of more sociodemographic information directly from enrollees.** AHIP and our members also welcome the opportunity to work with CMS to educate Medicare enrollees about the value of self-reported sociodemographic data and the guardrails for protecting the privacy and security of their data.

+ Support broader data collection through a phased approach. Sociodemographic data collected and reported by health plans, hospitals, clinicians, and other providers is critical in informing care and in identifying and reducing health disparities. **We recommend CMS support incremental steps to facilitate broader data collection and reporting by stakeholders on a wider set of sociodemographic data.** Plans, hospitals, clinicians, and other organizations will need to design, align, implement, test, evaluate, and revise data collection and application workflows. Accordingly, CMS should focus initially on a small number of social needs and/or demographic data elements with interoperable codes, and then add additional data elements in subsequent years in a phased approach.

+ Support alignment of data standards. A major challenge to equity efforts is that health plans, hospitals, and clinicians are following various federal and state data collection requirements on demographics and social needs. Varying data collection standards hinder

[44] AHIP letter, "Improving Demographic Data Standards to Advance Health Equity," October 2022. Available online at: https://www.ahip.org/documents/AHIP-Letter-on-Demographic-Data-Standards-with-Appendix.pdf.
[45] 88 FR 5375, January 27, 2023.
[46] AHIP letter, "Improving Demographic Data Standards to Advance Health Equity," October 2022. Available online at: https://www.ahip.org/documents/AHIP-Letter-on-Demographic-Data-Standards-with-Appendix.pdf.

efforts to aggregate, analyze, and enable apples-to-apples comparisons across markets and across health care entities and the ability to measure improvement. Having interoperable patient demographic data would allow the health care ecosystem to collect this data when most appropriate and convenient for patients and share the information with other partners with patients' consent to inform their care and population health management efforts, as well as to more effectively address disparities in access to care and outcomes. To promote interoperability across different standards and codes, AHIP mapped our demographic data standards to standardized codes (e.g., LOINC, SNOMED, ICD-10) and developed a data documentation framework that provides guidance on how frequently each question should be asked and how various responses should be coded.[47] **We recommend CMS support alignment of demographic data standards at the ecosystem level through federal policy changes to advance health equity.**

+ Incentivize use of standardized codes. Use of standardized codes by providers continues to lag. Many providers are still not aware of the availability and value of codes (such as Z codes, LOINC codes, or SNOMED codes) to document patients' health-related social needs. Many electronic health record (EHR) systems do not have easy ways to add Z codes to a patient's problem or diagnostic list. Providers also have concerns with adding Z codes to a patient's problem or diagnostic list because the provider may then feel responsible for addressing the patient's health-related social needs that occur outside of the clinician's office. **We recommend CMS educate providers about the value of standardized coding. Additionally, CMS should consider developing incentive programs to increase provider use of standardized codes. CMS should also work with ONC to incentivize EHR system developers to implement modifications that facilitate the use of all available interoperable codes, including Z codes, LOINC codes, and SNOMED codes.**

We also have the following comments and recommendations related to the other health equity proposals:

- Improvements to provider directories. MA plans work continuously to improve provider directories. Maintaining accurate directories is a shared responsibility between clinicians, facilities, and health insurance providers. Despite the best efforts of health insurance providers, including direct outreach to providers, electronic solutions, advanced analytics and artificial intelligence methods, and ongoing validation and audits, directories remain less than 100 percent accurate. Experience shows there are two formidable barriers to ensuring fully accurate provider directory information: (i) many providers do not consistently provide updates to their contact information, or they may provide inaccurate information; and (ii)

[47] AHIP letter, "Improving Demographic Data Standards to Advance Health Equity," October 2022. Available online at: https://www.ahip.org/documents/AHIP-Letter-on-Demographic-Data-Standards-with-Appendix.pdf.

there is no single "source of truth" for provider information that can be leveraged to verify information contained in directories.

We believe a public-private partnership between the federal government, providers, payers, and solutions vendors is needed to streamline collection of directory information and improve directory accuracy. AHIP supports CMS' proposal to explore a National Directory of Healthcare Providers & Services (NDH) as indicated in our comments in response to CMS' request for information on development of an NDH.[48] AHIP has recommended that CMS first work with stakeholders to develop the core set of provider directory data elements (such as languages spoken) supported by the NDH, as well as potential extension elements that may be required. A cohesive, national approach to building a technology-enabled infrastructure would help ensure accuracy of directories, reduce burdens on providers and plans, and improve efficiency. CMS should also conduct a provider directory education campaign to encourage providers to respond to questions from health plans related to provider directories and related provider information.

AHIP and our members appreciate the importance of non-English speaking patients or those with limited English proficiency being able to receive care in their preferred language. However, we have heard from AHIP members who operate Medicaid managed care organizations (which are already subject to a regulatory requirement regarding cultural and linguistic capabilities in provider directories), that despite good faith efforts to collect this type of data, many providers do not share information on the languages they speak or their cultural capabilities. Thus, when a provider returns a question about cultural and linguistic capabilities with a 'blank' data field, it is unclear whether this means that for example the provider only speaks English, or whether the information was simply not included. **If this provision is finalized, we ask CMS to use its authority to encourage healthcare provider organizations to maintain this data for their own individual clinicians, so that accurate and complete information may be provided to MA organizations and other payors.**

We also note that the prescribing of medications for opioid use disorder (MOUD) is an area that is evolving, particularly with the recent enactment of Section 1262 of the Consolidated Appropriations Act of 2023 (CAA), which removed the federal requirement for practitioners to submit a Notice of Intent (i.e., have a waiver commonly referred to as an "X-Waiver") to prescribe medications, like buprenorphine, for the treatment of opioid use disorder. **Given the recent enactment of this legislative provision that likely will significantly expand the number of eligible prescribers, we recommend CMS not adopt its directory proposal related to prescribers of MOUD. CMS should first consider and analyze the impact of**

[48] AHIP Press Release, "Working with CMS to Improve Provider Directories Accuracy," October 2022. Available online at: https://www.ahip.org/news/press-releases/ahip-looks-forward-to-working-with-cms-to-improve-provider-directories-accuracy.

the recent legislative change on its proposal and then modify its proposal with a new notice and comment opportunity.

For the reasons discussed above, AHIP recommends CMS delay the requirement for the proposed new directory data elements until solutions like an NDH are further explored and implemented to address the challenges of provider directories. If CMS moves forward and adopts these two new data elements for MA provider directories, we urge CMS not to penalize plans undertaking good faith efforts to collect information and improve their provider directories until the NDH or an equivalent solution is available to providers and plans.

- Digital health education. While telehealth helps increase safe access to care, especially during a pandemic, it can create or exacerbate disparities in access by leaving some populations behind. Research conducted prior to the pandemic revealed that older Americans, people residing in rural communities, vulnerable populations, racial and ethnic minorities, and people with lower socioeconomic means are disadvantaged by this "digital divide" and may be unable to take full advantage of telehealth opportunities.[49] Many individuals face challenges to using telehealth, including a lack of access to the internet; an inability to afford the technologies needed to access telehealth, such as phones, computers, connectivity devices, and data plans; and a limited understanding of how to access virtual care.[50]

  AHIP member plans embrace digital solutions that help increase access to care and want to ensure that the enrollees they serve can access safe and convenient care, regardless of where they live or their economic situation. To that end, many health insurance providers continue to work with their provider partners to bridge the digital divide. Low digital health literacy is a significant obstacle in achieving telehealth equity, and many older adults with low digital health literacy experience gaps in access to the health care they need.

  We support CMS' proposal for MA plans to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy. Additionally, we appreciate and support CMS' proposal to provide MA plans with broad flexibility to design their own digital health literacy screening programs or procedures. Consistent with CMS' proposal to provide plans with broad discretion, we recommend that plans should be able to use a program that is narrow in scope during the initial years to meet this requirement. This would allow plans more time to assess and test various screening and educational tools and programs for feasibility and effectiveness. This flexible approach would also allow for innovation. There are currently different definitions, standards, and vocabulary related to digital health literacy, and the field continues to evolve.

[49] AHIP Issue Brief, "Bridging the Digital Divide for Consumers." Available online at: https://www.ahip.org/documents/202011-AHIP_IB-DigitalDivide.pdf.
[50] Id.

We also encourage CMS to develop a working group comprised of AHIP members and other stakeholders that could come together to consider and discuss research-driven standards, studies, and examples of effective programs to improve digital health literacy.

- Change to quality improvement program requirements. Quality improvement programs are an important vehicle for MA plans to develop and execute activities designed to reduce disparities in health and health care, and advance equity in the health and health care of MA enrollee populations, especially those that are underserved. MA plans are already addressing disparities and gaps in care for underserved populations through a variety of quality initiatives. **We appreciate and support CMS' proposal to provide MA plans with broad discretion in the types of activities they can develop and implement to meet this proposed new quality improvement program requirement.**

B. Behavioral Health in Medicare Advantage (MA) (§§ 422.112, 422.113, and 422.116)

CMS proposes several changes to MA program requirements intended to improve access to behavioral health (BH) services in MA including the following:

- Addition of three new BH specialty types to network adequacy standards. CMS proposes to add clinical psychology, clinical social work, and prescribers of MOUD to network adequacy time and distance evaluations.

- Application of telehealth credits to the three new BH specialty types. CMS proposes to apply the 10-percentage point telehealth credit policy to help MA plans satisfy network adequacy requirements for the three new BH specialty types listed above.

- Addition of BH services to care coordination programs. CMS proposes to add BH services to the list of services for which MA plans must have a care coordination program in place to ensure continuity of care.

- Codification of appointment wait time standards for primary care and BH services. CMS proposes to codify in regulation appointment wait times recommended in sub-regulatory guidance for primary care services and to also extend these suggested wait times to BH services: (i) urgently needed services or emergency—immediately; (ii) services that are not emergency or urgently needed but require medical attention—within 1 week; and (iii) routine and preventive care—within 30 days.

Discussion and Recommendations:

AHIP members are committed to ensuring that MA enrollees have access to the covered BH services they need. Americans are continuing to experience a dramatic increase in BH needs, including in the areas of mental health and substance use disorders (SUD). The increase in demand is outpacing the supply of BH professionals. The Government Accountability Office's (GAO) October 2022 report[51] on the BH professional workforce in the U.S. included the following findings: (i) approximately half of U.S. counties did not have an active psychiatrist or addiction medicine specialist; (ii) more than 150 million people live in federally designated mental health professional shortage areas; and (iii) in the near future, the U.S. will face shortages of mental health providers ranging from 14,280 to 31,109.

In the face of these challenges, MA plans have taken important steps to optimize the existing workforce and improve access to BH services including the following:

- Understanding consumers' experiences accessing BH services. In June 2022, AHIP conducted a nationwide survey[52] of enrollees in MA plans and other kinds of health coverage to understand their experiences accessing care, whether their treatments were covered by insurance, and if insured patients were satisfied with the results. The survey results make it clear: an overwhelming majority of individuals report being satisfied with the mental health care they sought and received through their health insurance providers. Key findings from AHIP's survey included: (i) nearly all respondents who sought mental health care for themselves or someone within their household over the past two years received treatment; (ii) nearly 3 in 4 insured Americans (73%) found it easy to get the care they needed; (iii) more than two-thirds of respondents were able to find an appointment with a provider in less than a month; and (iv) 9 in 10 reported being satisfied with the mental health support they received, including half who said they were very satisfied.

- Access to behavioral telehealth services. MA plans also continue to advance a variety of solutions to further improve access to BH services, including expanding access to telehealth and digital tools for BH services. Telehealth and digital tools can help Medicare enrollees better engage in their health by offering convenience and flexibility. That is why **AHIP strongly supports CMS' proposal to apply telehealth credits to the three new BH specialty types as discussed below.**

- BH integration. Another area of focus for health insurance providers has been integrating mental health support into primary care settings. For example, health insurance providers have promoted collaborative care and enhanced care coordination models by providing primary care clinicians with tools and training to identify and care for their patients' mental

[51] Behavioral Health: Available Workforce Information and Federal Actions to Help Recruit and Retain Providers. Government Accountability Office. October 21, 2022.
[52] AHIP Mental Health Access Survey. June 2022. Available online at: https://www.ahip.org/resources/ahip-mental-health-access-survey-june-2022.

health needs. This allows primary care clinicians to be better equipped to integrate physical and mental health care, treat mild/moderate conditions, and consult with or refer patients to specialists when appropriate. **We continue to encourage CMS to consider the inclusion of the Collaborative Care Model (CoCM) and other enhanced care coordination approaches to support BH integration in future Center for Medicare and Medicaid Innovation (CMMI) demonstration models.**

- AHIP Board of Directors Statement of Commitment. On August 23, 2022, AHIP's Board of Directors released a new Statement of Commitment[53] and a detailed advocacy vision[54] to further improve access to mental health care and SUD treatment for every American. These commitments build on health insurance providers' extensive history of improving access to effective, high-quality care and treatment choices, while offering new solutions for public sector and private market partners to work together to overcome barriers that persist.

In addition to noting the concerted efforts by AHIP and our members to improve access to and quality of BH services, we have the following specific comments and recommendations in response to several BH related provisions included in the proposed rule.

- Addition of three new BH specialty types to network adequacy standards. Regarding clinical social work, we ask CMS to clarify that all disciplines that fit within this category (e.g., licensed independent social workers) would be countable toward meeting adequacy standards. We are concerned, however, about the ability of the current exceptions process under the MA program to address legitimate network challenges that MA plans may face with the proposed addition of the three new BH specialty types (clinical psychology, clinical social work, and prescribers of MOUD) to the MA network adequacy standards. For example, MA plans could face challenges meeting the time and distance standards due to a variety of factors, including but not limited to provider shortages, contracting practices, geographic issues, and other unique community characteristics or health care needs. Plans should also be able to use other provider specialty types (e.g., mental health counselors, licensed therapists, nurse practitioners, etc.) to satisfy the BH related network adequacy requirements. Accordingly, **if CMS were to finalize this proposal, the factors discussed above should be incorporated into the exceptions process for network adequacy, in addition to the justifications allowed under current rules. We also urge CMS to provide more time for plans to meet the standards by delaying the effective date until CY 2025.**

[53]AHIP Board of Directors Statement of Commitment. August 2022. Available online at: https://www.ahip.org/resources/ahip-board-of-directors-statement-of-commitment-improving-access-to-and-quality-of-mental-health-and-addiction-support.
[54] AHIP Statement, "A Vision for Improved Mental Health Care Access for Every American." Available online at: https://www.ahip.org/resources/a-vision-for-improved-mental-health-care-access-for-every-american.

In addition, as noted above, the prescribing of MOUD is an area that is evolving, particularly with the recent enactment of Section 1262 of the CAA, which removed the federal requirement for practitioners to submit a Notice of Intent (i.e., obtain a waiver commonly referred to as an "X-Waiver") to prescribe medications, like buprenorphine, for the treatment of opioid use disorder. Given the recent enactment of this legislative provision **that significantly expands eligible prescribers, we recommend CMS not adopt its proposal related to prescribers of MOUD. CMS should first consider and analyze the impact of the recent legislative change on its proposal and then modify its proposal with a new notice and comment opportunity.**

- Application of telehealth credits to the three new BH specialty types. Expanding access to BH care through telehealth, virtual visits, and other innovative uses of technologies can connect people to the BH support they need. If CMS finalizes this proposal, **AHIP strongly supports CMS' related proposal to apply the 10-percentage point telehealth credits to the three new BH specialty types (clinical psychology, clinical social work, and prescribers of MOUD).**

- Addition of BH services to care coordination programs. AHIP and our members support the goal of including BH services as part of MA plans' care coordination programs. However, **we recommend CMS provide additional time for plans to secure and implement the necessary contracts to add BH services to existing care coordination programs. We urge CMS to delay implementation of this proposal to CY 2025.**

- Codification of appointment wait time standards for primary care and extension to BH services. As discussed earlier, provider availability for BH can vary considerably based on a number of factors outside of plan control. Those and other factors can also affect appointment wait times for BH and primary care providers (PCPs). That is why we appreciate CMS' current guidelines in Chapter 4 of the Medicare Managed Care Manual (MMCM) that provide examples of reasonable appointment wait times for PCPs and also recognize that plans should have the flexibility to consider other factors, including "the enrollee's need and common waiting times for comparable services in the community."[55] We are concerned that the proposal to mandate requirements for primary care without the flexibilities identified in the MMCM, and extending such requirements to BH, would place additional burden on providers and may discourage them from participation in MA plan networks in the future. The expiration of the COVID-19 public health emergency (PHE) declaration could also impact providers and plans in meeting these standards, especially for BH services. For example, if federal rules such as the Ryan Haight Act are reinstated, in-person appointments would be required (in lieu of telehealth) for addiction services or to prescribe controlled substances for BH conditions. **We urge CMS not to adopt strict rules**

[55] Chapter 4 of the Medicare Managed Care Manual, Section 110.1.1, Provider Network Standards.

for appointment wait times and continue to provide plans with flexibility in meeting these network standards consistent with current sub-regulatory guidelines.

D. Enrollee Notification Requirements for Medicare Advantage (MA) Provider Contract Terminations (§§ 422.111 and 422.2267)

CMS currently requires MA plans to make a good faith effort to provide notification to MA enrollees at least 30 calendar days before the effective date of termination of a provider network participation contract. The rule currently applies to enrollees who are patients seen on a regular basis by the provider whose contract is terminating. (CMS proposes to codify sub-regulatory guidance that defines "regular basis" as "enrollees who are assigned to, currently receiving care from, or have received care within the past three months from a provider or facility being terminated".) However, for PCPs, the notice requirement applies to all enrollees who are patients of that PCP. CMS is proposing to modify these rules and to specify the requirements for the content of the notification to enrollees about a provider contract termination. Specifically, CMS proposals would:

- Preserve the phrase "good faith effort" for enrollee notification timeframes for for-cause provider contract terminations but remove "good faith effort" for no-cause provider contract terminations. CMS reasons that MA organizations should be able to meet a CMS established enrollee notification requirement in these no-cause cases on a timely basis.

- For patients of terminating PCPs: (i) extend the notice requirement to all enrollees who have ever been patients of these terminating PCPs (not just current patients); (ii) increase the notice requirement from 30 to 45 calendar days; and (iii) require both written and telephonic notice for contract terminations (the standard is written only for other provider types). MA organizations would be required to continue attempting to reach the enrollee by telephone to provide notice of the termination of the provider from the network when a call goes unanswered.

- Apply those same special rules for terminating PCPs to terminating BH providers.

CMS is also soliciting comment on two issues: 1) how many telephonic attempts are required to notify enrollees of a provider termination, and 2) whether an enrollee who is impacted by a provider contract termination should be eligible for an SEP.

Discussion and Recommendations:

While AHIP supports efforts to ensure enrollees have accurate, up-to-date information about their MA plan, including providers leaving the plan's network, we have several concerns with the proposals described here:

- The assumption that notification can always be provided at least a certain period of time before a no-cause termination ignores the reality that in many cases, providers fail to provide adequate notice when choosing to leave the network. The plan can have limited ability to enforce a timely notice requirement in a network contract, as the key enforcement tool – removal from the plan network – is the very action the provider has taken. **We urge CMS to retain the "good faith" standard when the provider is the party terminating the contract.**

- Requiring notification to any enrollee who has ever seen a terminating BH provider or PCP is unreasonable. An enrollee who receives notification of a provider termination after having seen the terminating provider only once, several years ago, is likely to view the notification as wasteful rather than helpful. While CMS cites continuity of care and the need to preserve ongoing provider relationships as justification for the expanded notification requirements for BH and PCPs, an individual who is no longer a current patient by definition does not have an ongoing relationship and is unlikely to be under an existing care plan with the provider. Therefore, **CMS should retain the existing notification requirements with respect to which patients should be contacted. At a minimum, CMS should limit the notification requirements to enrollees who have seen the terminating BH provider or PCP in the past year.**

- The proposal to require notification by phone every time a primary care or BH provider leaves the plan's network may be unhelpful and unwelcome by many enrollees. As CMS notes elsewhere in the proposed rule, many enrollees already report receiving too many phone calls. There is a significant risk that many will view a phone call notifying them of a provider termination for which they have already received written notice (and for a provider they may have not interacted with for years) as unnecessary and bothersome. Moreover, members may be more likely to misinterpret multiple phone calls as 'spam' calls that have nefarious intent. We also note that the requirement would add administrative burdens relating to messaging, tracking, and receiving increased call center inquiries following unanswered calls and voicemails. This will increase plan costs, which ultimately could have negative impacts on bids and benefits. The proposal also ignores the reality that providers leaving a plan's network are likely to contact affected patients who have approaching appointments.

  We urge CMS to withdraw this proposal and retain existing regulatory requirements that require enrollee notification by mail. Written notices provide enrollees with the time needed to digest the information and decide on the best action based on the information provided and offer an opportunity for the individual to share clear, accurate information with caregivers or trusted advisors for assistance in decision-making. In the event CMS finalizes the requirement for plans to notify enrollees by phone whenever a BH or PCP the individual has ever seen leaves the plan's network, we also ask

that CMS clarify how this requirement interacts with the recent announcement from the Federal Communications Commission of enforcement of rules that limit certain calls made to a residence.[56]

E. Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (§§ 422.101, 422.112, 422.137, and 422.138)

CMS proposes a number of significant changes related to UM and prior authorization (PA) requirements under MA including:

- Permitted uses of PA. CMS proposes to specify that MA plans are permitted to use PA for one or more of the following purposes: (i) to confirm the presence of diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service; (ii) for basic benefits, to ensure an item or service is medically necessary based on standards specified in § 422.101(c)(1) (which includes the permissible coverage criteria in the regulations; the assessment of whether an item or service is reasonable and necessary under the Medicare statute; the enrollee's medical history, physician recommendations and clinical notes; and involvement of the MA organization's medical director as appropriate); or (iii) for supplemental benefits, to ensure that the furnishing of a service or benefit is clinically appropriate.

- Adherence to Medicare FFS guidelines. CMS would specify that MA plans must comply with general coverage and benefit conditions included in original Medicare laws, including coverage criteria for inpatient admissions, requirements for coverage of Skilled Nursing Facility (SNF) Care and Home Health Services, and Inpatient Rehabilitation Facilities (IRF) coverage criteria. CMS indicates this would require MA plans to follow specific coverage criteria established in applicable Medicare statute, regulations, national coverage determinations (NCDs), and local coverage determinations (LCDs), when making medical necessity determinations.

- Ability to use internal plan coverage criteria for other benefits. Under the proposal, when coverage criteria are not fully established in applicable Medicare statute, regulation, NCDs or LCDs, MA plans would be permitted to create and use internal coverage criteria to make medical necessity determinations provided certain conditions are met:

[56] https://www.federalregister.gov/documents/2023/01/20/2023-00634/limits-on-exempted-calls-under-the-telephone-consumer-protection-act-of-199.

+ The coverage criteria would have to be based on current evidence in widely used treatment guidelines or clinical literature that is made publicly available. (The proposal would define "widely-used treatment guidelines" and acceptable clinical literature.)

+ MA plans would need to provide a public summary of evidence that was considered during the development of the plan's internal coverage criteria for medical necessity determinations, a list of sources of such evidence, and an explanation of the rationale supporting the adoption of the coverage criteria.

- Establishment of UM committee. CMS would require MA plans to establish a "Utilization Management Committee to review all utilization management, including prior authorization policies, annually and ensure they are consistent with current, traditional Medicare's national and local coverage decisions and guidelines."[57]

- Length of approvals and transition requirements. CMS proposes to require, with respect to basic benefits, that MA plans provide for an enrollee undergoing an active course of treatment: (i) approval of a PA request for the entire duration of the approved course of treatment, and (ii) for an enrollee who enrolls in an MA plan (including enrollees new to a plan and new to Medicare), a minimum 90-day transition period when the active course of treatment had previously started, even if furnished by an out-of-network provider. The proposal says that the MA plan "must not disrupt or require reauthorization" for such active course of treatment during the 90-day transition period.

CMS explains several important implications of the proposed changes – for step therapy and for existing coverage flexibilities in areas such as discharges from acute care hospitals.

First, when MA plans are required to adhere to specific Medicare guidelines, step therapy would be permitted only to the extent the step therapy is permitted under the original Medicare guidelines. (At the same time, CMS indicates that MA plans could still use PA to deny coverage for a particular item or service if it is not reasonable and necessary based on the medical necessity determination requirements in the Medicare guidelines.) Conversely, when MA plans are allowed to create internal coverage criteria under CMS' proposal, step therapy would be permissible - if current evidence in widely used treatment guidelines or clinical literature require another item or service to be provided first. CMS also notes this proposal does not affect Part B drugs for which existing rules authorize use of step therapy in certain cases.

Second, CMS specifies in the preamble that MA plans would be restricted in the ability to limit "when and how" they cover basic Medicare FFS benefits.[58] CMS explains that "when care can

[57] 87 FR 79452 at pages 79454-79455.
[58] 87 FR 79452 at page 79502.

be delivered in more than one way or in more than one type of setting, and a contracted provider has ordered or requested Medicare covered items or services for an MA enrollee, the MA organization may only deny coverage of the services or setting on the basis of the ordered services failing to meet the [Medicare coverage rules]."[59] This restriction applies even to cases where an MA plan denies a particular item or service and redirects the enrollee to a different clinically appropriate item or service. CMS acknowledges this would be narrower than current policy, established in a June 2000 final rule, which provided that "…when a health care service can be Medicare-covered and delivered in more than one way, or by more than one type of practitioner, that an MA plan could choose how the covered services will be provided."[60] Thus, for example, if an enrollee in an MA plan is "discharged from an acute care hospital and the attending physician orders post-acute care at a SNF because the patient requires skilled nursing care on a daily basis in an institutional setting, the MA organization cannot deny coverage for the SNF care and redirect the patient to home health care services unless the patient does not meet the coverage criteria required for [Medicare FFS coverage of] SNF care."[61]

CMS also requests comments on early termination of services in post-acute care settings by MA plans and other possible changes to better manage incentives between MA plans and post-acute care providers to deliver the best possible care for Medicare beneficiaries. Additionally, CMS encourages MA plans to adopt gold carding programs that would allow providers to be exempt from PA and provide more streamlined medical necessity review processes for providers who have demonstrated compliance with a plan's gold carding requirements.

Discussion and Recommendations:

AHIP has the following comments and recommendations in response to CMS' expansive set of UM proposals:

Background on value of PA. AHIP appreciates CMS' acknowledgement in the proposed rule that UM policies are an important means to coordinate care, reduce inappropriate utilization, and promote cost-efficient care under MA. Our members support the use of evidence-based clinical policies, including those specified under Medicare FFS rules and guidelines, to ensure the right care is provided to MA enrollees at the right place, and at the right time.

PA is one of many tools health insurance providers use to promote safe, timely, evidence-based, affordable, and efficient care. MA plans and other health insurance providers have adopted a range of evidence-based UM tools, including PA, to help ensure patients receive optimal care based on well-established evidence of efficacy and safety, while providing benefit to the individual patient. Under the supervision of medical professionals, PA can reduce inappropriate

[59] 87 FR 79452 at page 79507.
[60] Id.
[61] 87 FR 79452 at page 79502.

care by catching unsafe or low-value care, or care not consistent with the latest clinical evidence. Low-value or otherwise inappropriate care can contribute to potential harm to patients and unnecessary costs.

The evidence showing the value of PA is clear. For nearly two decades, numerous studies have documented that Americans frequently receive inappropriate care in a variety of settings for many different medical procedures, tests, and treatments.[62] The Institute of Medicine has confirmed that geographic variations in spending are substantial, pervasive, and persistent over time and there is little to no correlation between spending and health care quality.[63] Needless medical tests are unsupported by evidence, causing harm and wasting billions. In a national survey of over 2,000 physicians, most (64.7%) reported at least 15-30% of medical care is unnecessary.[64] A January 2023 study also demonstrates how savings associated with PA far exceed the administrative costs.[65]

The MA program rules support the use of PA as a critical tool to ensure Medicare enrollees receive safe, effective, and appropriate care. Moreover, CMS has repeatedly recognized PA as an important tool to protect patients and has taken a number of actions to thoughtfully expand its use under original Medicare. Additionally, in response to recommendations from the GAO[66] and the Medicare Payment Advisory Commission (MedPAC),[67] original Medicare has implemented evidence-based guidelines and PA for outlier professionals to address the overuse and misuse of imaging services, which can expose patients to unnecessary and potentially harmful radiation, unnecessary surgery and office visits, undue stress, and add wasteful costs to the health care system.

In July 2022, AHIP posted a comprehensive report[68] on how health insurance providers have delivered on their commitments to improve PA for patients and providers. This report follows up

---

[62] AHIP Medical Management Resources. Available online at: https://www.ahip.org/issues/medical-management.
[63] Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Care; Board on Health Care Services; Institute of Medicine; Newhouse JP, Garber AM, Graham RP, et al., editors. Variation in Health Care Spending: Target Decision Making, Not Geography. Washington (DC): National Academies Press (US); 2013 Oct 1. Summary. Available from: https://www.ncbi.nlm.nih.gov/books/NBK201637/.
[64] Lyu H, Xu T, Brotman D, Mayer-Blackwell B, Cooper M, Daniel M, et al. (2017). "Overtreatment in the United States." PLoS ONE 12(9): e0181970. https://doi.org/10.1371/journal.pone.0181970.
[65] Brot-Goldberg, Z., Burn, S., Layton, T., Vabson, B. "Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare." January 2023.
[66] GAO Report. "Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending." Available online at: https://www.gao.gov/products/gao-18-341#:~:text=GAO%2D18%2D341%20Published%3A,or%20items%20like%20powered%20wheelchairs.
[67] MedPAC Chapter 10: Medicare Coverage Policy and Use of Low-Value Care (June 2018 report). Available online at: https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun18_ch10_medpacreport_sec-pdf/.
[68] AHIP report available online at: https://www.ahip.org/documents/AHIP-1P-Consensus-Statement-Actions-072722-FINAL.pdf

on the 2018 Consensus Statement[69] among providers, health insurers, and other stakeholders recommending opportunities to improve the PA process. Since then, health insurance providers have taken and continue to take concrete actions to help achieve the shared goal of making PA more efficient, more effective, and less burdensome.

Below we identify specific proposals we support, as well as concerns and recommendations on other proposals. We recommend that CMS work with plans and providers to ensure these processes work as effectively as possible. Health insurance providers are continually improving PA programs to reduce physician and enrollee burdens and improve outcomes for patients. We also urge CMS to adopt policies that encourage widespread provider adoption of electronic prior authorization (ePA) technology and look forward to submitting recommendations to increase adoption of ePA by providers in our comments in response to CMS' Advancing Interoperability and Improving PA proposed rule.[70]

Proposals we support:

- Clarification of standards. Despite the importance of PA and the steps health insurance providers have taken to make PA more efficient, more effective, and less burdensome, we acknowledge that providers and others continue to raise concerns about the burdens and impacts of PA along with questions about the scope of permissible PA. For that reason, **we support CMS providing additional clarity about the scope of permissible PA.** However, as noted below, we are concerned that certain aspects of the proposal would eliminate long-permitted flexibilities which have allowed MA plans to encourage high-quality, cost-effective care alternatives. We also have other concerns about the proposal, including the proposed effective date for implementing new restrictions and process mandates relating to PA that are discussed in more detail below.

- Public summary of evidence requirement. **We support CMS' requirement for plans to make publicly available the evidence that they considered during the development of their internal medical necessity coverage criteria. CMS should also provide plans with flexibility for meeting the requirement for making this information publicly available.** This proposal would increase transparency into MA plans' medical necessity decision making and ensure consumers and others are better informed about the evidence-based coverage criteria that MA plans use to make medical necessity determinations.

- Establishment of UM committee. In the preamble, CMS indicates that its proposed requirement for MA plans to establish a UM committee would enable the UM committee to

[69] 2018 Prior Authorization Consensus Statement. Available online at: 2018 Prior Authorization Consensus Statement.
[70] 87 FR 76238, December 13, 2022.

operate similarly to a plan's Pharmacy and Therapeutics (P&T) committee. CMS would require plans to meet committee membership requirements outlined in the rule but would also provide plans with flexibility to define the structure and appropriate additional responsibilities of the UM committee. **We support CMS' proposal to provide flexibility for plans to meet this requirement but also recognize that plans may need more time to identify qualified committee members. CMS notes that MA plans could establish a UM committee that largely mirrors their P&T committee. We recommend that CMS also clarify in the final rule that to support efficiencies, MA plans could also use their UM committee to meet the existing P&T committee requirements. Additionally, we recommend CMS permit MA plans, or the parent organization of one or more MA plans, to use one UM committee to serve multiple MA plans when the MA plans are offered under the same legal entity.**

Proposals that raise concerns:

- Adherence to Medicare coverage guidelines – in general. AHIP members have expressed concerns about circumstances under which coverage criteria specified under original Medicare are not fully established or are ambiguous. Required adherence to questionable clinical criteria under original Medicare could lead to worse patient health outcomes, higher costs for the Medicare program, and fewer affordable, high-quality plan choices for beneficiaries. While the proposed rule permits the use of internal plan criteria when original Medicare coverage criteria are not fully established, **we further recommend CMS ensure the agency has a process in place to consider questions and provide clarity on which Medicare guidelines fail to meet the regulatory requirement and therefore permit use of internal plan coverage criteria.**

  We have also heard concerns about guidelines that may be in place but do not reflect current medical or scientific evidence or literature. In such cases, there could be increased risks of patients receiving low value care and experiencing adverse health impacts. **We urge CMS to ensure that NCDs are timely reviewed to reflect the most recent medical or scientific evidence or literature. We further encourage CMS to ensure that Medicare Administrative Contractors (MACs) are timely reviewing LCDs to ensure that they are also based on the most recent medical or scientific evidence or literature.**

  Finally, we have serious concerns that the proposal would require MA plans to follow "coverage criteria for inpatient admissions at 42 CFR 412.3." That regulatory provision includes CMS' "two-midnights" policy for determining when an individual qualifies for an inpatient admission under original Medicare. CMS guidance acknowledges that the two-midnights rule is a "Medicare claims processing procedure" and CMS has said it would not interfere with how MA plans and contracted hospitals establish their criteria for determining

inpatient admissions as compared to observation stays.[71] The proposal would reverse this approach, thereby interfering with MA/hospital contracting and likely raising costs for delivering MA benefits. Moreover, applying the two-midnights rule to MA enrollees would not expand coverage for items or services, but could (depending on plan design) actually impose higher cost sharing liabilities on enrollees. We also note that unlike original Medicare, MA plans have the authority and commonly cover a skilled nursing facility stay without a preceding three-day inpatient admission, further limiting any benefit the proposal could have in terms of coverage for post-acute care. **We urge CMS to modify any final provision to carve out the two-midnights policy from Medicare coverage requirements to which MA organizations must adhere.**

- Limits on use of step therapy. There are medical conditions that may have several medical coverage or medication options. Although their clinical effectiveness may be the same, the patient safety considerations and coverage costs may be very different. Step therapy enables an enrollee to obtain the item, service, or medication they need, but at a lower cost. In 2019, CMS acknowledged the value of step therapy when the agency affirmatively permitted MA plans to apply step therapy to manage Part B drugs.[72] In August 2018, CMS stated that "using step therapy plans could ensure that a senior who is newly diagnosed with a condition begin treatment with a cost-effective biosimilar before progressing to a more costly drug therapy should the initial treatment be ineffective. By implementing step therapy along with care coordination and drug adherence programs in MA, it will lower costs and improve the quality of care for Medicare beneficiaries."[73] **We urge CMS to consider more flexibility to allow step therapy by MA plans that reflects current medical or scientific evidence or literature, even if not expressly permitted under specific original Medicare guidelines. We strongly support CMS' continued flexibility with respect to step therapy for Part B drugs and believe similar benefits to patients and taxpayers could be realized for other items and services.**

- Post-acute care and similar limits on use of PA. We have very serious concerns with CMS' proposal to eliminate more than 20 years of flexibility under the MA program to limit "when and how" original Medicare covered benefits are covered. This proposal would undermine efforts to move towards value-based care and would increase overall costs under the program and thereby adversely affect enrollees and taxpayers without improving patient health outcomes. CMS' Medicare FFS demonstrations have shown that care can be delivered in more than one way or in more than one type of setting. For example, CMS' Comprehensive Care for Joint Replacement Model and Bundled Payments for Care Improvements Model have shown that greater use of home health care instead of institutional post-acute care can

[71] 78 FR 50495 at page 50934.
[72] CMS Fact Sheet. Available online at: https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-prior-authorization-and-step-therapy-part-b-drugs.
[73] Id.

reduced costs without harming patient outcomes. These results have also been discussed in peer-reviewed publications, and these strategies have been implemented by many organizations, including accountable care organizations. A recent Kaiser Family Foundation assessment of post-acute care utilization research found that MA enrollees use less institutional post-acute care in comparison to original Medicare enrollees, with similar or slightly better outcomes.[74,75] MA plans play a vital role in ensuring that their enrollees have access to high-quality, cost-effective care. Limiting plan flexibilities to manage post-acute care would undermine efforts to move towards value-based care and increase costs without improving patient health outcomes. **We therefore urge CMS to not adopt policies that would place limits on plan flexibility to manage post-acute care.**

- 90-day transition period coverage requirement. In the preamble, CMS explains that its 90-day transition period coverage proposal "mirrors Part D transition requirements and using the same period will ensure consistency across the MA and Part D programs. In addition, use of one consistent transition period will likely make it easier for new enrollees to understand their transition coverage."[76] CMS also proposes to define an active course of treatment as "a course of treatment in which a patient is actively seeing the provider and following the course of treatment."[77]

  We are very concerned about the implementation challenges, including the broad coverage scope, associated with the 90-day transition period coverage requirement. The proposed requirement to cover transitional care without the ability to apply PA could increase the risk of fraud, waste and abuse and could have other unintended consequences for the program. We also believe that the 2024 proposed effective date is premature. In its Advancing Interoperability and Improving PA proposed rule[78] CMS' proposal to require a Payer-to-Payer application programming interface (API) to facilitate exchange of information between payers regarding a PA coverage decision for an active course of treatment does not take effect until 2026. We believe this exchange capability should be operational prior to the implementation date for this new coverage requirement. **We strongly recommend CMS delay and not finalize the 90-day transition period coverage requirement proposal until unintended consequences are addressed and until the Payer-to-Payer API is fully functioning. If CMS decides to finalize this proposal, we urge the agency to apply a 2026 effective date.**

---

[74] Ochieng, N. and Biniek, J. "Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature." September 2022. Available online at: https://www.kff.org/report-section/beneficiary-experience-affordability-utilization-and-quality-in-medicare-advantage-and-traditional-medicare-a-review-of-the-literature-report/.
[75] Barnett ML, Wilcock A, McWilliams JM, et al. "Two-year Evaluation of Mandatory Bundled Payments for Joint Replacement." *N Engl J Med*. 2019;380(3):252-262.
[76] 87 FR 79452 at page 79505.
[77] 87 FR 79452 at page 79714.
[78] 87 FR 76238, December 13, 2022.

- Full course of treatment requirement. The proposed definition and preamble discussion related to "course of treatment" is broad in scope. It is unclear whether this proposed coverage requirement applies to a continuity of care period or would require approval in perpetuity. We are concerned that it may be misinterpreted to mean that there is no clear time limitation and potentially no limitation on a provider continuing to furnish services that are outside the scope of the original coverage approval. This uncertainty could allow for inappropriate coverage. This lack of clarity could also increase risk for fraud, waste and abuse and costs for beneficiaries and the health care system as a whole. **We recommend CMS clarify in the final rule its definition and coverage expectations related to a "course of treatment." CMS should also provide examples of what is and is not permissible to ensure that treatments that are not medically necessary under Medicare FFS guidelines are not required to be covered under this policy. It is also unclear whether a plan would be required to approve the exact course of treatment included in the original coverage request. This clarity is needed to ensure consistent application of CMS' policy. We believe CMS policy should also ensure that plans have the ability to approve periodic courses of treatment consistent with their internal plan coverage criteria. Additionally, we recommend that in the final rule, CMS make it clear that its transition coverage requirement is limited to 90 days. CMS should allow a plan to work with their MA enrollee after the 90-day transition period to find an in-network provider to continue their care.**

- Encourage use of gold carding programs. Health insurance providers remain committed to improving the PA process. As part of health insurance providers' long-standing commitment to the 2018 Consensus Statement and continued process improvements, AHIP recently surveyed health insurance providers on the use and impact of gold carding programs with a focus on how these programs impact patient care. AHIP's research[79] found that the use of gold carding has increased since 2020—and gold carding programs are most effective when they are used selectively and are continually re-evaluated to ensure patients are receiving the high-quality care they deserve. Additional findings included: (i) health insurance providers are using gold carding programs more frequently to improve efficiency and speed; (ii) gold carding programs work better for some services than others; (iii) gold carding programs include providers with sufficient PA volume and low denial rates; (iv) frequent reviews of provider performance are vital; (v) gold carding programs have mixed reviews; and (vi) concerns about care quality for patients and challenges with implementation are top reasons for discontinuing gold carding programs. **AHIP agrees that gold carding can be helpful in targeting PA requirements where they are needed most and reducing the**

[79] AHIP Survey on Gold Carding Programs. July 2022. Available online at: https://www.ahip.org/resources/new-survey-effective-gold-carding-programs-are-based-on-evidence-and-value-for-patients.

administrative burden on high-performing health care providers. AHIP considers gold carding programs to be a contract issue between a plan and a network provider. As such, and given the varied experience and customized nature of effective gold carding programs, AHIP does not support the mandating of these programs under MA.

- Effective Date. Given the volume and complexity of the changes CMS proposes to make under the UM requirements section of the regulation, MA plans should be provided at least two additional years to implement any finalized requirements. As previously indicated, by the time this rule is finalized, plans may only have several weeks to fully assess all the changes to existing program requirements, adequately reflect these changes in their 2024 bids, modify contracts, and make systems and other operational changes needed to meet the 2024 effective date. Moreover, if the proposal for establishment of a UM committee is finalized, each plan committee would be required to review and possibly have to modify all UM policies to ensure that they are consistent with MA program rules. This work would be considerable and time-consuming. **We therefore urge CMS to delay the effective date to 2026 for new regulatory requirements focused on UM, including the establishment of a UM committee, that are finalized under this rule. A 2026 effective date would not only provide plans with sufficient time to meet new requirements, but also aligns with CMS' proposed 2026 effective date for its Advancing Interoperability and Improving PA proposed rule[80] that impacts MA plans.**

F. Request for Comment on the Rewards and Incentives Program Regulations for Part C Enrollees (§ 422.134 and Subpart V)

CMS asks for stakeholder feedback on whether the agency should issue additional guidance on the definition of "cash equivalent" within the context of MA rewards and incentives programs and the use of gift cards that may be redeemed only at specific retailers.

Discussion and Recommendations:

AHIP supports the use of rewards and incentives programs as a means of encouraging healthy behaviors and promoting the efficient use of health care resources among MA enrollees. We appreciate CMS' ongoing commitment to providing guidance to MA organizations on the design and use of such programs to drive better health outcomes.

We believe additional guidance on the definition of "cash equivalent" within the context of rewards and incentives program would be helpful, and ask CMS to clarify rules on the offering of gift cards that can be redeemed at specific retailers or a specific category of items or services as reward items. As CMS notes in the rule's preamble, there are currently

[80] 87 FR 76238, December 13, 2022.

several different interpretations on the permissible use of such gift cards. Additional guidance from CMS will ensure that MA organizations are able to provide appropriate incentives and rewards as part of efforts to improve enrollee health and wellness.

H. Review of Medical Necessity Decisions by a Physician or Other Health Care Professional with Expertise in the Field of Medicine Appropriate to the Requested Service and Technical Correction to Effectuation Requirements for Standard Payment Reconsiderations (§§ 422.566, 422.590, and 422.629)

Current regulations state that if an MA organization expects to issue a partially or fully adverse medical necessity decision based on the initial review of the request, the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before the MA organization issues the organization determination decision. CMS proposes to require that for adverse medical necessity decisions, coverage determinations would have to be reviewed by a licensed physician or other appropriate health care professional with expertise in the field of medicine or health care that is appropriate for the service at issue. Under the proposal, the health care professional would not need to be the same specialty or sub-specialty as the treating physician or health care professional; CMS indicates that plans would have discretion to determine on a case-by-case basis what constitutes appropriate expertise based on the services being requested and relevant aspects of the enrollee's health condition.

Discussion and Recommendations:

AHIP agrees that health care professionals making coverage decisions should have the expertise in the field of medicine or health care that is appropriate for the service at issue. **We also strongly support CMS' decision not to require the case reviewer involved to be of the exact same specialty or sub-specialty as the treating physician. Such a restrictive approach would not only be cost-prohibitive but would be highly problematic.** In the proposed rule, CMS provides an example of a qualified reviewer. CMS explains that "if a plan intends to deny a request for a home nebulizer, the organization determination request should be reviewed by a health professional with respiratory expertise, such as a respiratory therapist."[81] We also believe that the language in the final rule should provide sufficient flexibility to support plan use of a physician specialized in for example internal medicine for this particular case. Internal medicine physicians are also familiar with the reasons why a home nebulizer may be medically necessary, such as for severe asthma or Chronic Obstructive Pulmonary Disease (COPD) and can order them.

[81] 87 FR 79452 at page 79510.

We therefore strongly support CMS' intent to allow flexibility for a plan to determine on a case-by-case basis what constitutes appropriate expertise based on the services being requested and relevant aspects of the enrollee's health condition, and to not require an exact match between the service requested and the qualifications of the reviewer. We urge CMS to modify the final regulatory text to make this flexibility and plan discretion clear.

M. Part C and Part D Midyear Benefit Changes and Part D Incorrect Collections of Premiums and Cost Sharing (§§ 422.254, 423.265, 423.293, 423.294)

CMS proposes to codify its longstanding prohibition of midyear benefit changes for MA and Part D. Additionally, CMS proposes to require Part D sponsors to: (i) refund incorrect collections of premiums and cost sharing, and (ii) recover underpayments of premiums and cost sharing.

Discussion and Recommendations:

Given that the COVID-19 PHE declaration may end in 2023, certain COVID-19-related waivers and flexibilities may also end at that time. **We recommend that CMS permit plans that have made mid-year benefit changes in 2023 to extend those changes through the end of the contract year.** This approach would ensure that enrollees do not lose a benefit during the plan year and enable plans to continue their efforts to ensure that enrollees have access to their benefits and necessary care.

N. Clarify Language Related to Submission of a Valid Application (§§ 422.502 and 423.503)

CMS proposes to codify that it does not evaluate or issue a notice of determination when an entity submits a substantially incomplete application. CMS also proposes to codify the definition of a substantially incomplete application as one that does not include responsive materials to one or more sections of its MA or Part D application.

Discussion and Recommendations:

AHIP supports codifying the definition of a substantially incomplete application. However, the proposed language does not make clear what constitutes a plan's good faith efforts to provide all required documentation. **We ask CMS to provide additional clarity on what evidence is acceptable to demonstrate that the plan has made best efforts to provide all necessary documentation.**

O. Updating Translation Standards for Required Materials and Content (§§ 422.2267 and 423.2267)

CMS proposes to require MA organizations and Part D sponsors to provide materials to enrollees on a standing basis in any non-English language that is the primary language of at least 5 percent of the individuals in a PBP service area and in accessible formats on request. CMS also proposes to extend this translation requirement to SNP enrollee individualized plans of care. In addition, the proposal would require that FIDE SNPs, HIDE SNPs, and applicable integrated plans translate all Medicare materials that would require translation into any languages required by their capitated Medicaid managed care contract in addition to language(s) required by the Medicare standard. CMS solicits feedback on the scope of this requirement, specifically whether other types of D-SNP plans should be required to meet this requirement as well.

Discussion and Recommendations:

We strongly support CMS' goal to ensure access to important information and materials for Medicare enrollees who have limited English proficiency or need auxiliary aids or services. This proposal applies to a broad range of written beneficiary materials. We have heard concerns about individual cases where it may be difficult to translate and provide a document to a beneficiary under tight timelines (e.g., braille translations could take several weeks). For those circumstances, the plan uses alternative means (e.g., verbal) to communicate the information with their beneficiary to not only meet timeliness standards, but also to appropriately balance the need for quick communication with the beneficiary. **We recommend CMS ensure that the requirement included in the final rule provides plans with flexibility and supports their best efforts to provide translated materials timely and ability to use alternative arrangements when needed to meet timeliness standards. Given the concerns raised above, we also ask CMS to establish a workgroup comprised of plans and other stakeholders that can come up with options for meeting this objective while balancing the need to communicate with beneficiaries quickly in certain circumstances.**

We support the concept of making SNP member care plans accessible to all members but as proposed, we are concerned with both the length of time translation of care plans could take as well as the potentially high costs of translation on a standing basis. Based on figures provided in CMS' Special Needs Plan Comprehensive Report for January 2023, the average SNP enrolls over 4,000 members; and in D-SNPs, the average is 5,825. Instead of requiring each care plan be translated on a standing basis, we believe it would be appropriate and more cost-effective to have a care team member verbally review the care plan in the member's chosen language following updates to the care plan. This approach would have the added benefit of improving member understanding and adherence to the care plan as they would have a team member to review the plan with them and the opportunity to ask questions. Following such a review, if the member requested written translation, the plan could then be required to translate the care plan into the member's requested language. **We urge CMS to modify its proposal to permit SNPs to have a care team member verbally review the care plan in the member's chosen language. If after**

such review the member requests translation, the plan should be required to translate the care plan into the requested language.

P. Medicare Advantage (MA) and Part D Marketing (Subpart V of Parts 422 and 423)

CMS proposes numerous changes related to the content of advertisements and other marketing encounters; new plan oversight rules relating to agents and brokers; and other new marketing rules, including new limits on scheduling of meetings. A number of those proposals and AHIP's comments are highlighted below.

Discussion and Recommendations:

America's older adults and people with disabilities deserve MA plans that continue to deliver better services, better access to care, and better value. And as they make choices about their coverage, Medicare enrollees should be protected from bad actors who engage in misleading advertising and marketing tactics. They should have clear, accurate, easy-to-understand information about MA plans to help them select the coverage option that best meets their needs. Open and honest information about their plans is essential to MA's ability to deliver high levels of satisfaction to enrollees. The industry is committed to ensuring truth in advertising and marketing practices.

Accordingly, AHIP and our members generally support CMS' proposals, which, when added to the robust oversight regime already in place, would protect beneficiaries from misleading advertising and reduce consumer confusion and abrasion.

We are concerned however that several of CMS' marketing related proposals could adversely impact beneficiaries and the resources they rely upon to make the right plan choice to best meet their health care and other needs. Several proposals also do not adequately account for needed implementation time. In addition to complying with state licensing and other requirements, agents and brokers are required to be trained and tested annually on Medicare program rules and regulations and on the specific plan benefits they sell. As members of their local communities, agents can also help plans connect with diverse Medicare populations, including racial and ethnic minorities, to ensure that they have the information and resources they need to inform their Medicare coverage selections. Proposals that unnecessarily limit or impose barriers on access to agents and brokers may prevent consumers from getting educated on critical information they need to make informed decisions. In addition, certain proposals, including those relating to marketing materials, will require the release of more detailed sub-regulatory guidance and may require training and implementation steps that will be difficult to complete if the final rule applied them to marketing for the 2024 plan year.

We have the following specific comments and recommendations on these and certain other proposals:

- Separation of education events from marketing. CMS proposes several changes to the marketing rules which are intended to separate educational events from marketing events. Specifically, CMS proposes to: reinstate the prohibition on accepting Scope of Appointment (SOA) cards or the collection of beneficiary contact information at educational events; prohibit MA plans and agents from setting up future marketing appointments at educational events; prohibit marketing events from taking place within 12 hours of an educational event in the same location; and prohibit personal marketing appointments from taking place until after 48 hours have passed since the time the SOA was completed by the beneficiary.

  CMS explains that these changes would help to "alleviate the pressure a beneficiary may feel to stay for a marketing event and will protect beneficiaries from undue pressures to enroll in a plan for which they may not be interested or a plan that does not best meet their health care needs."[82] We are concerned that these proposed changes would have the opposite effect; they could deprive Medicare enrollees the ability to have in-person interactions and conversations, which studies suggest Medicare enrollees strongly prefer.[83]

  We also are concerned that de-linking education events from marketing could adversely impact dual eligible individuals and result in health inequities. Our members have shared that a higher share of dual eligible individuals enroll through face-to-face encounters with agents and brokers. At the same time, they often face unique challenges such as lack of access to transportation services and technology that makes it difficult to schedule multiple meetings; it is critical that they have access to information and resources in one interaction. The proposed 12-hour wait time after an educational event and 48-hour wait time after completion of an SOA could therefore impose absolute barriers on attending a subsequent meeting, potentially limiting their ability to choose a plan that best meets their health care and other needs. The wait times could also adversely impact beneficiaries who need to make a plan selection but are facing an immediate enrollment deadline. **For these reasons, we strongly recommend that CMS not adopt its proposals that would separate educational events from marketing, including the provisions that prohibit marketing events from taking place within 12 hours of the educational event in the same location; and personal marketing appointments from taking place until after 48 hours have passed from the completion of the SOA. If CMS does finalize its proposal to require a 48-hour wait time**

[82] 87 FR 79452 at page 79530.
[83] Rivera-Hernandez M., Blackwood K.L., Mercedes M., Moody K.A. "Seniors Don't Use Medicare.Gov: How Do Eligible Beneficiaries Obtain Information about Medicare Advantage Plans in the United States?" BMC Health Services Research 21, 146, February 2021; Shupei, Yuan, Syed A. Hussain, et. Al. "What do they like? Communication Preferences and Patterns of Older Adults in the United States. The role of technology, Educational Gerontology, 42:3, 163-174, 2016.

after completion of an SOA, we urge the agency to permit plans to add an opt-out choice on the form if the beneficiary wishes or needs to meet with the agent sooner than 48 hours.

- Timelines. In general, CMS does not explicitly indicate the effective date for these proposed changes in marketing rules, which suggests the intent would be for those proposals to apply for the marketing period for plan year 2024. However, plans must have access to all necessary marketing guidance and sufficient lead time to implement changes for CY 2024. In order for plans to meet this deadline, CMS would have to issue the final rule and provide MA plans with any required sub-regulatory operational guidance by early May 2023 at the latest**.** This would include sub-regulatory guidance for the new third-party marketing organization (TPMO) related requirements (e.g., disclaimers, submission of marketing materials directly to CMS, waivers that apply to EGWPs). CMS also indicates that it would provide more detailed sub-regulatory guidance on questions and areas that would have to be covered during the pre-enrollment discussion with an enrollee. MA plans will also need time to assess the changes in order to develop advertising materials and submit them to CMS for approval; and for agent/brokers to obtain training and modify their processes to reflect the numerous provisions in the proposed rule. Given the breadth and scope of the proposed changes, we are concerned about the timing of these changes, especially if CMS is considering a CY 2024 (Fall 2023 Annual Enrollment Period (AEP)) effective date. **If CMS is unable to issue the final rule and required sub-regulatory guidance by April/May 2023, we recommend that CMS delay the effective date to CY 2025 (Fall 2024 AEP).**

- Agent/Broker oversight. CMS proposes to require MA plans to establish and implement an oversight program that monitors agent and broker activities, identifies non-compliance with CMS requirements, and requires plan reporting of non-compliance to CMS. In the preamble, CMS explains that an acceptable oversight program includes: "the review of internal grievances, 1–800–MEDICARE complaints, random samplings of past audio calls, listening to sales/marketing/ enrollment calls in real-time, secretly shopping in-person education and sales events, and secretly shopping web-based education and sales events."[84] In addition, CMS notes that plans should be able to identify non-compliant agents and brokers through these activities and would be expected to "quickly act, such as [pursuing] tailored training or disciplinary measures, based on the specific issues for each agent or broker"[85] and also report the agent or broker non-compliance to CMS.[86] AHIP members have already taken steps to improve oversight of agent and broker activities including implementing activities described above.

[84] 87 FR 79452 at page 79534.
[85] Id.
[86] Id.

We appreciate CMS not proposing overly prescriptive requirements in regulation for MA plans to implement. We anticipate there are a number of clarifying questions that CMS will receive through the public comment process that should be addressed to ensure common understanding and consistent application. For example, we ask CMS to clarify whether reporting of agent/broker noncompliance would be limited to significant and/or repeated noncompliance actions. We also reiterate our previous recommendation that CMS not hold a MA plan liable for a non-compliant activity of a TPMO or other entity with whom the MA plan does not contract (directly or through a sub-contract). Finally, we continue to recommend that CMS establish a forum for engagement with AHIP, MA plans, the States, agents and brokers, and other TPMOs, and beneficiary advocates to discuss and address marketing-related concerns.

Q. Changes to an Approved Formulary (§§ 423.4, 423.100, 423.104, 423.120, and 423.128)

In subsection Q.2.b.(3), CMS proposes new flexibility for Part D plans to make midyear formulary changes for certain drugs. Specifically, under this proposal Part D sponsors would be allowed to immediately substitute: (1) a new interchangeable biological product for its corresponding reference product; (2) a new unbranded biological product for its corresponding brand name biological product; and (3) a new authorized generic for its corresponding brand name equivalent.

Discussion and Recommendations:

AHIP and its members have long championed the use of generic versions of small molecule drugs as an alternative to more expensive brand/originator versions when they become available. Indeed, since the enactment of the Hatch-Waxman Act, nearly 90% of all drugs dispensed in the Medicare program are generics.[87] The ability of Part D plans to use well-tested formulary management and negotiating tools, including the promotion of cost-effective and clinically appropriate generics, has been critical in plans' ability to keep Part D premiums steady despite exorbitant launch prices for new drugs and out-of-control drug price increases on existing medicines. While the dynamics of the biologic/biosimilars large molecule drug market are more complex, the prospect of growing numbers of interchangeable and biosimilar versions of brand biologics presents new opportunities for patients to obtain greater access to these expensive, but highly effective medicines. **Accordingly, we appreciate and support CMS' efforts to provide plan sponsors with the flexibility to quickly make formulary changes regarding these follow-on biologics.** This additional flexibility provides Part D plans with additional means to promote innovation, patient safety and cost effectiveness for consumers and taxpayers.

R. Part D Medication Therapy Management (MTM) Program (§ 423.153(d))

[87] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar19_medpac_ch14_sec.pdf.

In general, Part D's statutory provisions impose certain requirements relating to MTM programs. For example, sponsors are required to target those Part D enrollees who have multiple chronic diseases, are taking multiple Part D drugs, and are likely to meet a cost threshold for covered Part D drugs established by the Secretary. To address its concerns that MTM is not being utilized to the fullest benefit for the broadest eligible patient populations in Medicare, CMS proposes several changes to the program's targeting criteria:

- CMS subregulatory guidance identifies 9 chronic disease targets for MTM programs, and current regulations provide plans flexibility in choosing which diseases to target. Under the proposal, Part D sponsors would be required to include all core chronic diseases in their targeting criteria. CMS would also codify the current 9 core chronic diseases in regulation and add HIV/AIDS for a total of 10 core chronic diseases.

- CMS would reduce the maximum number of covered Part D drugs a sponsor may require for MTM Program eligibility from 8 to 5 drugs while also mandating sponsors include all Part D maintenance drugs.

- Under its current methodology, the cost threshold for covered drugs is $4,935 in 2023. CMS would revise the cost threshold methodology based on the average annual cost of 5 generic Part D drugs (e.g., $1,004 in 2020).

Discussion and Recommendations:

AHIP and our members have long supported the use of MTM programs in Part D. Medication use in the Medicare population is significant, with patients currently averaging 54 prescriptions per member annually,[88] with >50% of beneficiaries 65 and older taking four or more prescription drugs daily.[89] The need to manage these treatments is a critically important task undertaken by plan sponsors and their contracted Pharmacy Benefit Managers (PBMs) to prevent adverse events and promote effective care. Accordingly, we appreciate CMS interest in expanding beneficiary enrollment in MTM programs.

However, we have the following significant concerns with the proposed changes to the MTM program criteria:

- As a threshold issue, CMS cites reports that only 9% of Medicare Part D enrollees are currently participating in MTM programs. CMS estimates that the proposed changes would

[88] https://www.cbo.gov/publication/57772#:~:text=Use%20of%20prescription%20drugs%20among,year%E2%80%94a%2013%20percent%20increase.
[89] https://www.kff.org/health-reform/issue-brief/data-note-prescription-drugs-and-older-adults/.

increase MTM enrollment to 23%, close to its 2005 projection of 25% MTM enrollment. But the fact that MTM program enrollment rates do not match original projections does not, in our opinion, justify the expansion of eligibility criteria. More critically, **focusing on the fact 9% of Part D enrollees are in MTM programs fails to account that other Part D enrollees receive medication care management through other means.**

+ Plans offer a variety of services, which can range from activities like screening for drug interactions through claims adjudication to more direct enrollee engagement through UM tools, wellness checks, etc. As part of this, plans may employ physicians, pharmacists, nurses, and other clinical experts in-house to engage patients on managing their medications—especially when specialty and other high-cost or complex drugs are involved. Those activities can accomplish the same care quality and safety aims of the formal MTM program for patients outside the current eligibility criteria—and at potentially significantly lower costs.

+ Contracted physicians and pharmacists also conduct regular outreach on patient therapy adherence consistent with clinical standards of care and their provider contracts with plan sponsors.

+ We are concerned that enhanced MTM eligibility could generate overlapping outreach efforts that could overwhelm beneficiaries, including patients with cognition issues, to the point where it discourages patients from participating in similar activities with plans, physicians and pharmacies that have a record of success. Beneficiaries cannot be helped by MTM programs or other plan outreach efforts if they request to be placed on "do not contact" lists in response to these changes.

- In addition, the proposed rule does not offer clear evidence suggesting increased enrollment in the MTM program will improve patient care outcomes. Prior analyses in fact have raised questions about the level of benefits and savings under the MTM program.[90] **We believe that before proposing to expand MTM program eligibility, CMS should provide an updated analysis that evaluates the effectiveness and costs of MTM programs and in comparison to the other non-MTM program-specific plan interventions/care management efforts noted above that may target the same (or similar) populations, before determining to expand MTM eligibility.**

- As noted, CMS estimates that the proposed changes would result in significant increases in enrollment. The agency also estimates that costs would increase by $336M annually, although CMS acknowledges that not all costs involved can be quantified due to the nature of

[90] https://innovation.cms.gov/data-and-reports/2022/mtm-fourth-evalrept.

administering these programs. While there is concern among our members that this estimate undercounts—perhaps significantly—those projected enrollment and cost burdens, even if those projections were to be proven accurate, **we have serious concerns with CMS proposing to increase plan MTM costs by 64% in a single plan year, including the need for rapid increases in staffing and administrative infrastructure, at the same time plans are gearing up to devote significant resources to implementing major program changes resulting from the recently enacted IRA**. In addition, CMS changes relating to pharmacy negotiated prices also take effect in 2024; we have noted our serious concerns with the impact of such changes as well. The combined impacts of these changes could further increase premium pressures and government costs.

- AHIP members have also shared their concerns that it would be difficult—if not impossible—to find enough pharmacists and other clinicians qualified to implement the proposed MTM program expansion mandate. While plans may seek to contract with outside vendors to help meet the added demand, a 2024 effective date would provide plans with limited time to adequately assess the quality of services to be provided so they can ensure high-quality services for patients and avoid abrasion, including potentially negative impacts on Star Ratings scores.

Accordingly, AHIP strongly recommends CMS withdraw these proposed changes and instead conduct additional research of MTM and alternative methods, and provide the results for public review and comment, so stakeholders can better assess the implications of the changes. Subsequently, those findings should drive future engagement with stakeholders—clinicians, plan sponsors, beneficiary advocates, etc.—on how to revise eligibility criteria and/or other program changes going forward. **However, if CMS chooses to finalize this proposal, we urge the proposed changes not be made effective for 2024, and that they be phased in over time to help mitigate potentially significant premium increases—especially in concert with pending IRA-mandated Medicare Part D changes to be implemented in the very near future.**

W. Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act (§§ 422.326I, 423.360(c), (§ 401.305(a)(2))

CMS proposes to revise the definition of when an MA plan or Part D sponsor has identified an overpayment by removing a reference to "reasonable diligence" and replace with language that gives the terms "knowing" and "knowingly" the same meaning given those terms in the False Claims Act.

Discussion and Recommendations:

AHIP supports this proposal.

IV. Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies

A. Amending the Definition of Severe or Disabling Chronic Condition; Defining C-SNPs and Plan Types; and Codifying List of Chronic Conditions (§ 422.2)

CMS proposes a number of codifications and changes relating to "chronic condition special needs plans" (C-SNPs). For example:

- CMS would modify the definition of special needs individual to reflect a statutory change in the Bipartisan Budget Act of 2018 to the definition of a severe or disabling chronic condition.

- CMS would codify the list of chronic conditions that meet the statutory definition by including (with some modifications) conditions previously provided through sub-regulatory guidance and adding additional categories recommended by a panel of clinical advisors. Those new conditions would include conditions relating to obesity and related conditions, chronic gastrointestinal disease, and post-organ transplantation care and immunodeficiency and immunosuppressive disorders. Moreover, the proposal would add as chronic conditions certain functional needs that may be similar even if the underlying disease or chronic condition may differ. CMS provides the following examples: conditions that may cause cognitive impairment; conditions that may cause similar functional challenges and require similar services such as spinal cord injuries; chronic conditions that impair vision, hearing (deafness), taste, touch, and smell; and conditions that require continued therapy services in order for individuals to maintain or retain functioning. CMS also requests input on whether MA organizations require further guidance related to the functional needs categories.

- CMS would codify current guidance regarding MA plans' ability to offer C-SNPs focused on single or multiple chronic conditions. For C-SNPs that restrict enrollment to individuals with multiple commonly co-morbid and clinically-linked conditions (CMCLC), CMS would codify the currently approved set of five CMCLC and add three additional groupings recommended by the clinical advisor panel. CMS would also clarify that CMCLC C-SNPs may enroll eligible individuals who have only one of the qualifying conditions listed in the approved groupings.

Discussion and Recommendations:

We appreciate that CMS is proposing to modify, clarify and expand the current list of 15 chronic conditions to 22 conditions beginning in 2025. We believe this adjustment is appropriate and in keeping with developments in standards of care. As part of this proposal, we support including functional categories as chronic conditions so that individuals with similar kinds of functional

impairments can benefit from targeted models of care even though their underlying diagnoses may vary.

In terms of CMS' request for input on more guidance that may be needed on the new functional categories, **we suggest that CMS take the approach of reviewing plan proposals for new C-SNPs organized around those functional categories and, based on that experience, determine whether additional guidance is needed**. We note that the acuity or extent of functional impairments across a group of individuals may vary significantly. In that regard, **CMS may wish to consider providing additional guidance on how and the extent to which an individual's level or degree of impairment should be considered as an element of eligibility criteria.**

CMS also requests comments on the proposal to limit the regulatory definition of "severe or disabling chronic condition" to those conditions recommended by the panel of clinical advisors. We believe that it is appropriate to rely on the recommendations of a panel whose members have appropriate expertise and maintain currency with clinical innovation and standards of care.

G. Clinical Trial-Related Provisions (§§ 422.101 and 422.109)

CMS proposes to adopt regulations regarding MA plan coverage of clinical trials covered by Medicare under NCD 310.1 and as part of Category A or B Investigational Device Exemption (IDE) trials. CMS proposes to codify that an MA enrollee's in-network cost sharing must be included in the plan's maximum out-of-pocket calculation. CMS also proposes to specify that MA plans may not require prior authorization for participation in a Medicare-qualified clinical trial not sponsored by the plan (nor create impediments to participation in such a trial).

Discussion and Recommendations:

AHIP and our member plans support Medicare coverage of clinical trial participation for beneficiaries across Medicare's coverage options. We appreciate CMS' efforts to ensure payment and coverage policies do not act as a barrier to such participation. We support the proposed regulations and clarifications relating to MA plan obligations regarding enrollee participation in covered clinical trials, including IDE trials. We encourage CMS to continue providing MA plans with information about clinical trials that qualify for Medicare coverage and MA plan responsibilities related to such trials.

O. Possible End Dates for the SEP for Government Entity-Declared Disaster or Other Emergency (§§ 422.62 and 423.38)

CMS proposes two (2) revisions to the end date(s) for the SEP for a government entity-declared disaster or other emergency. First, in the case of a State or local emergency or disaster where a

specific end date of the emergency or disaster is not declared, the end date for the SEP may also be based on the emergency or disaster order automatically expiring pursuant to a State or local law, if such a law exists. Second, if no end date for the emergency or disaster period is specified, the SEP would end one year after the SEP start date.

Discussion and Recommendations:

AHIP supports the proposed revisions to the end dates for SEPs resulting from State or local emergency or disaster declarations. While SEPs for individuals affected by such disasters are important for protecting enrollees' ability to access care and needed benefits, the lack of clear end dates for SEPs lead to confusion and uncertainty. CMS' proposed specifications for SEP end dates in cases where the emergency or disaster end date is not clearly specified will provide certainty for both enrollees and plans.

AH. Gross Covered Prescription Drug Costs (§423.308)

To address a newly perceived ambiguity regarding interpretation of this term, CMS is proposing to revise its regulatory definition for Gross Covered Prescription Drug Costs (GCPDC) to fully "mirror" the statutory language in §1860D-15(b)(3) of the Social Security Act (SSA) by stripping the words "actually paid" from the regulatory definition in §423.308 in the Code of Federal Regulations (CFR). It is notable that the regulatory definition already mirrored the statutory language, but for the addition of the words "actually paid."

Discussion and Recommendations:

In the preamble, CMS states that this change ". . . would not constitute a change in policy or require a change in operations under Part D, and thus would not place any additional burden or reduce burden on Part D sponsors, nor result in government savings or costs." CMS also briefly notes that the GCPDC definition is incorporated into provisions of the IRA, specifically, those relating to new CMS negotiating authority for certain prescription drugs. While CMS explains at length why the change does not affect the calculation of reinsurance or have other Part D benefit implications, we believe the agency should also explain what, if any, effects the change could have under the IRA provisions such as the selection of drugs for negotiation or other implications. Without such explanation, it can be difficult for stakeholders to fully assess the consequences of the change or provide meaningful comment. **Therefore, we urge CMS to explain the potential effects of this change under the provisions of the IRA.**

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (42 CFR 422.162, 422.164, 422.166, 422.260, 423.182, 423.184, and 423.186)

The MA Star Ratings program incentivizes plans to achieve high performance on quality and plays a vital role in helping millions of diverse individuals continue to have access to high-quality, coordinated care, affordable benefit offerings, and options they deserve and rely on. MA plans with Star Ratings of at least 4 stars receive increased funding as an incentive to achieve high performance. In turn, high performing plans use Star Ratings rebate funds to reduce cost-sharing and offer additional benefits to Medicare enrollees. For example, MA plans can offer dental, vision, and hearing aid benefits, as well as other benefits, including those that can address socioeconomic barriers to health. Star Ratings is also one of many factors reflected in the Medicare Plan Finder (MPF) tool to help Medicare enrollees choose between available plans in their service area.

Given the value of the Star Ratings program to MA enrollees, we have serious concerns about the combined impact of the proposed changes to the Star Ratings program that would make it more difficult for MA plans to achieve 4 or more overall Star Ratings. CMS estimates that its proposed changes would save a total of almost $25 billion over 10 years. We offer comments below about specific components of these proposals but we emphasize our general concern that the cumulative impact of the proposed changes could result in reducing additional benefits offered by plans or increasing cost-sharing for Medicare beneficiaries without improving quality of care. Reducing supplemental benefit offerings in particular would run counter to the Administration's health equity goals, as supplemental benefits support plan efforts to advance them.

D. Adding, Updating, and Removing Measures (§§ 422.164 and 423.184)

CMS proposes to make a number of measure-specific and other changes under this Star Ratings proposal:

- Data Collection. CMS proposes to add collection of data through alternative sources or modes of collection to the list of non-substantive measure updates that can be made without rulemaking under existing regulations. For example, if a web mode of survey administration is added to the current mail with telephone follow-up of non-respondents survey administration that is currently used for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey and the Health Outcomes Survey (HOS), CMS would consider this to be a non-substantive change that could be announced without going through the rulemaking process because, CMS reasons, there would only be a change in the method of collection and not a change in the information collected.

- Parts C & D Measures. CMS proposes to make a number of changes to the measures included in the Parts C and D measure set, including implementing risk adjustments for the three Part D medication adherence measures.

Discussion and Recommendations:

- Data Collection. While we support the addition of alternative modes of data collection to the Star Ratings program requirements, we do not agree that this change is non-substantive. Differing survey modalities have been shown to produce varying results, even when the same survey questions are asked.[91,92] Additionally, survey modality preferences differ by age groups,[93,94] which may also affect the population responding and, therefore, the survey results. We believe adding a web-based data source for the surveys, especially CAHPS, would likely increase the number of respondents which could have a significant impact on the numerator or the denominator and subsequently a plan's performance results. **We therefore recommend that CMS finalize this policy change as a substantive change in accordance with existing Star Ratings rules that cover substantive updates.**

  Parts C & D Measures.

  + Part D Medication Adherence for Diabetes Medication, Medication Adherence for Hypertension (RAS Antagonists), and Medication Adherence for Cholesterol (Statins) measures. CMS proposes to implement risk adjustment for the three Part D medication adherence measures based on sociodemographic status (SDS) characteristics for 2028 Star Ratings. CMS also proposes to implement other changes to these measures, including removing the adjustment for stays in inpatient (IP)/skilled nursing facilities (SNF), starting with the 2026 measurement year (2028 Star Ratings). To prepare for the application of SDS risk adjustment for the medication adherence measures, **AHIP and our members recommend CMS provide more details on the risk adjustment methodology for these measures to allow for additional assessment and input.** For example, information should be provided on whether plans will test against their own population or if vendors will test against the entire Medicare population and give plans the adjustment at the end of the period. Plans need to better understand these and other details to forecast performance and make other adjustments. Several AHIP members have also raised concerns about CMS' plans to remove the adjustment for IP/SNF stays from the medication adherence measures starting with the 2026 measurement year (2028 Star Ratings). CMS indicates that its analysis revealed that this change would have minimal impact on ratings. However, AHIP members are concerned that this change would be

[91] Keeter, S. "*Methods Can Matter: Where Web Surveys Produce Different Results than Phone Interviews.*" PewResearch.org. Available online at: https://www.pewresearch.org/fact-tank/2015/05/14/where-web-surveys-produce-different-results-than-phone-interviews/.
[92] Christensen A, Ekholm O, et. al. "Effect of Survey Mode on Response Patterns: Comparison of Face-to-Face and Self-administered Modes in Health Surveys." Eur J Public Health. 2014.
[93] Palonen M, Kaunonen M, Åstedt-Kurki P. "Exploring How to Increase Response Rates to Surveys of Older People." Nurse Res. 2016.
[94] Gigliotti, L. and Dietsch, A. "Does Age Matter? The Influence of Age on Response Rates in a Mixed-Mode Survey." Human Dimensions of Wildlife. 2014.

impactful. **We also recommend that CMS provide plans with more details on its analysis related to the removal of the IP/SNF stay adjustment prior to finalizing this proposed change.**

+ Part D Concurrent Use of Opioids and Benzodiazepines, Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults, and Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults measures. CMS proposes to add these three Part D measures to the 2026 Star Ratings. These measures are currently on display. AHIP and our members have concerns with CMS' proposal to move these three measures from the display page to Star Ratings for 2026. While we recognize the potential harmful impacts associated with the use of these medication regimens in the Medicare population, we do not support adding these measures to Star Ratings as they may hamper a plan's ability to support appropriate medication use and ensure access to care. We have several concerns. First, we want to ensure that mental health conditions that may impact the use of these medications are appropriately accounted for and note that there are cases where concurrent use may be appropriate, which is not reflected in the measures' specifications. Second, we are concerned that concurrent use, defined under the specifications for these measures, as overlapping days greater than or equal to 30 days in the measurement period, may not provide plans with adequate time to assess whether the benefit of concurrent use outweighs the risk and to coordinate activities with prescribers. Third, some medications included in these measures would require dosage tapering and management of withdrawal symptoms which are clinical practices and patient safety measures that are also not accounted for in the measures' specifications. Finally, we believe CMS should delay the addition of these measures to Star Ratings due to the impact the proposed changes to the Part D Medication Therapy Management (MTM) eligibility requirements could have on plan performance on these measures if finalized. **We urge CMS to delay adding these Part D measures to the Star Ratings until the concerns we and our members have raised are fully considered and addressed.**

E. Measure Weights (§§ 422.166(e) and 423.186(e))

CMS proposes to lower the weight of patient experience/complaints and access measures from 4 to 2 beginning with the 2026 Star Ratings.

Discussion and Recommendations:

For several years, AHIP has recommended that CMS decrease the weight of CAHPS measures used in Star Ratings from 4 to 2. We have raised concerns about the current disproportionate weight for CAHPS measures in comparison to evidence-based clinical quality outcome measures. Reducing the weight of CAHPS measures to "2" would result in these measures being

weighted higher than process measures but not as high as clinical quality outcome measures. In addition, this change is consistent with one of the goals of CMS' Quality Strategy[95] and would align more closely with the weight these types of measures are given in other CMS quality programs. **AHIP agrees with CMS' proposal to lower the weight of CAHPS measures from 4 to 2.**

We also ask CMS to consider the comments submitted by AHIP members on this topic. In addition, we appreciate that CMS continues to work with the Agency for Health Research and Quality (AHRQ) and National Committee for Quality Assurance (NCQA) to research longer-term solutions to improve the CAHPS survey and response rates. Such potential approaches could include reducing the length of the survey; increasing sample size; and revising the questions to better reflect the current health care delivery system, including use of telehealth and non-physician clinicians. Additionally, removing questions from surveys addressing circumstances falling outside of a health insurance provider's control or with low reliability and/or validity would make room on the survey for questions that could be used to measure emerging quality issues and address health equity concerns without increasing the burden on respondents. **We welcome the opportunity to engage with CMS on comprehensive evaluation and field testing of improvements to the CAHPS survey.**

F. Guardrails (§§ 422.166(a)(2)(i) and 423.186(a)(2)(i))

CMS proposes to remove guardrails when determining measure-specific cut points for non-CAHPS measures starting with 2026 Star Rating.

Discussion and Recommendations:

In the preamble, CMS explains that the intent of the guardrails policy is to improve predictability and stability of Star Ratings measure cut points from one year to the next. CMS believes that the combination of the mean resampling and Tukey outlier deletion (set to take effect with 2024 Star Ratings) would provide "sufficient predictability and stability of cut points from one year to the next."[96] In the preamble, CMS explains that the guardrails, which were created in the 2019 final rule, were intended to increase the predictability and stability of cut points because recent experience calculating Star Ratings during the PHE showed that they were unable to keep pace with any unanticipated changes in industry performance. As a result, CMS believes the guardrails policy is no longer necessary. We believe that CMS should not be making a permanent methodological change based on the extraordinary situation experienced during the recent public health emergency. **We do not agree that the current use of mean resampling along with application of the Tukey outlier deletion (set to take effect with 2024 Star**

[95] 83 FR 16440 at page 16521, April 2018.
[96] 87 FR 79452 at page 79626.

Ratings) would be an adequate substitute that increases cut point predictability and stability.

AHIP maintains that setting pre-determined cut points are the most effective way for CMS to improve predictability and stability under the Star Ratings program. Regarding value-based arrangements with providers, setting goals in advance of the measurement period is essential to helping plans and their network providers assess the effectiveness of their efforts to improve quality of care and reduce costs while maintaining high performance and rating levels. Moreover, setting cut points in advance of the measurement period reduces burdens on providers contracting with multiple plans who otherwise may face varying and conflicting quality performance metrics on the same quality measures. Setting cut points in advance of the measurement period would also support several CMS guiding principles for MA Star Ratings, including aligning Star Ratings with the current CMS Quality Strategy, ensuring contracts are treated fairly and equally, driving quality improvement, minimizing unintended consequences, and supporting transparency.[97] We believe that establishment of pre-determined thresholds is the best means to ensure transparency, predictability, stability, and quality improvement.

The use of pre-determined cut points also aligns with principles of quality improvement. The Institute for Healthcare Improvement's (IHI) Model for Improvement is a widely accepted framework for quality improvement programs.[98,99] Setting quality aims and identifying measurement targets is the model's fundamental starting point. For the MA program, measure-specific cut points can serve as quality improvement aims. Additionally, pre-determined cut points could identify "stretch goals" that align with IHI's quality aims best practices to incentivize plans to identify and direct care toward populations experiencing health disparities that require individualized quality improvement solutions. Establishing pre-determined cut points for measures linked to clinical disparities can help plans set goals to aim quality improvement efforts toward populations with unique needs. Use of pre-determined cut points also empowers consumer choice as consumers are increasingly relying on categorical ratings and scores to inform their decisions. With the increasing number of MA plan choices that are available, pre-determined cut points could help clearly and meaningfully communicate the value of each MA plan to the beneficiary. For example, a beneficiary with diabetes may be most interested in choosing a plan with high Star Ratings on diabetes care measures.

We therefore do not support the elimination of the guardrails policy and the introduction of the Tukey outlier deletion (per our prior comments on this issue). Instead, AHIP recommends CMS assess and consider proposing the setting of cut points for Star Ratings

---

[97] Id.
[98] Institute for Healthcare Improvement, "Science of Improvement: How to Improve." Available online at: https://www.ihi.org/resources/Pages/HowtoImprove/default.aspx.
[99] Langley, G., Moen, et. al. "The Improvement Guide: A Practical Approach to Enhancing Organizational Performance." 2nd Edition. April 2009.

measures well in advance of the measurement period. As discussed above, pre-determined cut points would enable MA plans and their network providers to better manage their quality care and health equity improvement efforts, allow for greater methodological transparency, and allow plans and their network providers to better understand the goals for each Star Ratings measure.

We also ask CMS to consider the comments submitted by AHIP members on this topic.

G. Health Equity Index Reward (§§ 422.166(f)(3) and 423.186(f)(3))

CMS proposes to use a health equity index (HEI) in the Part C and Part D Star Ratings starting with the 2027 Star Ratings (which would include data from the 2024 and 2025 measurement periods). The HEI adjustment would reward contracts for obtaining high measure-level scores for the subset of their enrollees with specified social risk factors (SRFs). The SRFs included in the HEI would be low-income subsidy or dual eligibility (LIS/DE), or disability. CMS also proposes to eliminate the reward factor after 2026 Star Ratings, contingent on finalizing the addition of the proposed HEI reward.

Discussion and Recommendations:

We appreciate the details CMS has included in the regulation regarding the agency's HEI proposal. **We support the goal of the HEI to further incentivize MA plans to focus on improving care for enrollees with SRFs. However, given the complexity of the proposal, we recommend CMS address questions raised about the HEI, perform additional modeling, and make additional changes as recommended below prior to finalizing and adding it to Star Ratings. We also oppose elimination of the reward factor, which could penalize high-performing plans.**

We have the following specific comments and recommendations about CMS' HEI and reward factor proposals:

- HEI. AHIP members have many questions about the HEI methodology that would need to be addressed before its introduction into Star Ratings. For example, plans need to learn more about the contract level proportions of enrollees with SRFs that would be included in the HEI. In addition, plans need to review the stratified measure performance reported by SRFs that would be included in the HEI. Plans would also appreciate CMS' feedback and analysis on whether the HEI should be treated as an adjustment or separate measure in Star Ratings.

  There are other aspects of the MA program that could impact a plan's HEI result that CMS should also address prior to finalizing this program requirement. For example, in the 2023

MA and Part D rule[100], CMS finalized its proposal to create a pathway for states to require D-SNPs with exclusively aligned enrollment to hold a "D-SNP only" contract starting with plan year 2025. AHIP members have raised concerns about the impact on a plan's HEI result if D-SNP only contracts are compared to non-D-SNP contracts under the proposed HEI reward system. Concerns have also been raised about the impact of the HEI adjustments for contracts that are too small or have other characteristics that would disqualify them for a positive adjustment under the HEI. For example, a plan may have many enrollees with SRFs under a large contract, but the percentage may be too small to make the contract eligible for an HEI adjustment. Furthermore, plans may have contracts with many enrollees with other SRFs that would not be captured by the proposed HEI methodology.

Given these concerns, we urge CMS to delay the introduction of the HEI into Star Ratings. We believe CMS should first address all questions and issues raised about the HEI during this comment period. Next, CMS should pilot test the HEI for at least one performance year and provide plans with confidential feedback reports, and then seek additional public comments prior to finalizing and adding the HEI to Star Ratings. This approach would ensure plans have an opportunity to understand, assess and provide meaningful feedback to CMS to promote accuracy, reliability, and utility of the HEI and its results. **We also ask CMS to consider specific comments about the HEI submitted by AHIP members.**

- Reward Factor. CMS also proposes to eliminate the reward factor after 2026 Star Ratings. In the preamble, CMS explains that the reward factor was added to Star Ratings to provide "additional incentives for high and stable relative performance across measures by discouraging contracts from having a lot of variation in performance across measures."[101] CMS further explains that over time the agency has established additional methodological changes (e.g., addition of Parts C and D quality improvement measures) to incentivize performance improvement across measures and therefore the reward factor is no longer needed. CMS further states that "[t]he removal of the current reward factor is contingent on finalizing the addition of the proposed HEI reward."[102]

  We have significant concerns regarding CMS' proposal to remove the reward factor from Star Ratings. Removal of the reward factor represents a significant change to the program and would result in penalizing consistently high-performing plans. CMS anticipates a 10-year Medicare savings estimate of $5.13 billion with the addition of the HEI and elimination of the reward factor. Star Ratings for high-performing plans with a disproportionate share of enrollees with SRFs could be adversely impacted with the addition of the HEI and elimination of the reward factor. Lower Star Ratings for high-performing

[100] 87 FR 27704, May 9, 2022.
[101] 87 FR 79452 at page 79626.
[102] 87 FR 79452 at page 79627.

plans due to the elimination of the reward factor could also adversely impact Medicare enrollees by reducing additional benefits offered by plans or increasing cost-sharing requirements. **We therefore oppose CMS' proposal to eliminate the reward factor and recommend the agency further analyze the potential adverse impacts of its proposal.**

H. Improvement Measure Hold Harmless (§§ 422.166(g)(1) and 423.186(g)(1))

Under the current improvement measure hold harmless provision, Part C and Part D scores are calculated both with and without the improvement measures, and contracts with 4 or more stars are held harmless from having the highest rating reduced by the addition of the improvement measures. CMS now proposes to modify the Part C and Part D improvement measure hold harmless provision to limit its application to contracts with 5 stars only beginning with the 2026 Star Ratings.

Discussion and Recommendations:

In the preamble, CMS indicates its belief that the hold harmless provision is not needed for contracts with 4 or 4.5 Star Ratings because these plans "still have the potential to increase scores across measures and thus their Star Ratings."[103] With this proposed change, CMS also anticipates a 10-year Medicare savings estimate of $19.53 billion.[104]

Given the variability of Star Ratings cut points year to year, we are very concerned that with the proposed change to the hold harmless policy for the improvement measures, slight differences in performance on a small number of measures could have an inordinately adverse impact on a high-performing plan's overall Star Ratings. We are also concerned that Part D plans will be undergoing significant operational changes due to implementation of IRA provisions, which could lead to more challenges hindering plans' ability to achieve higher Star Ratings that are not necessarily indicative of performance or care quality. Although CMS views this policy change as a way to encourage continued quality improvement, it could result in penalizing high-performing plans. We believe that given the complexity and rigorous nature of the Star Ratings program, achieving and maintaining 4 stars takes tremendous effort and should not be discounted.

We are further concerned that CMS' proposed change to limit the application of the improvement measures' hold harmless policy could adversely impact MA beneficiaries. The existing hold harmless policy has driven quality improvement across measures. MA plans with a Star Rating of at least 4 stars receive increased funding as an incentive to achieve high performance. Plans use these funds to provide additional benefits and reduce beneficiary cost-sharing. Health plans that obtain the quality bonus payment for achieving 4-Stars or higher are

[103] 87 FR 79452 at page 79632.
[104] 87 FR 79452 at page 79702.

able to offer more robust supplemental benefits such as dental, vision, hearing aids, meals, nutrition, transportation, and in-home services and supports. These enhanced benefit offerings are also critical to addressing social drivers of health and advancing health equity. Limiting the offering of these benefits for disadvantaged populations would work against the Administration's health equity goals and could worsen disparities in health outcomes. Changes to the Star Ratings program should support, not take away, vital benefits. **We therefore oppose CMS' proposal to modify the Part C and Part D improvement measure hold harmless provision and urge the agency to not adopt this policy change.**

I. Extreme and Uncontrollable Circumstances (§§ 422.166(i) and 423.186(i))

CMS proposes to modify its extreme and uncontrollable circumstances policy by no longer applying the "60 percent rule" starting with 2026 Star Ratings. The 60 percent rule excludes, for all non-CAHPS measures, the numeric scores for contracts with 60 percent or more of their enrollees living in a FEMA-designated Individual Assistance area when calculating cut points for non-CAHPS measures.

Discussion and Recommendations:

AHIP supports the removal of the "60 percent rule" for extreme and uncontrollable circumstances and recommends CMS adopt this proposal in the final rule.

Other Star Ratings Comments

AHIP has additional comments on other Star Ratings issues for CMS' consideration.

Discussion and Recommendations:

- **Impact of IRA implementation on Star Ratings.** We are concerned about the unanticipated impacts that implementation of IRA provisions will have on certain Star Ratings measures and plan performance. Beneficiary complaints and confusion as well as other factors outside of plan control could impact plan performance on various measures including, but not limited to, survey and administrative measures (e.g., complaints, disenrollment). **We recommend that CMS consider applying a hold harmless policy for 2024 and 2025 Star Ratings years through an interim final rule or other mechanism to ensure that summary and overall Star Ratings for individual plans do not go down if lower performance results are likely due to IRA impacts.**

- **Part D MTM Program Completion Rate for CMR.** CMS is proposing to make significant changes to the Part D MTM program requirements. Included are multiple changes to the enrollee targeting/eligibility criteria to improve access for enrollees CMS asserts could

benefit from these services. Accordingly, any of the changes that CMS finalizes related to the MTM program requirements should be considered as substantive changes under the Star Ratings program rules at §423.184. **We recommend CMS address the impact of these substantive changes to the Part D MTM measure in a future rule for additional stakeholder input prior to finalizing the proposed changes to the MTM program requirements.**

- **Part C and Part D Members Choosing to Leave the Plan Measures.** Several AHIP members have raised concerns about the impact of IRA implementation and other factors that could unfairly impact plan performance on the Part C and Part D Members Choosing to Leave the Plan measures. Under the IRA, Medicare enrollees who take insulin have access to an SEP in 2023 which could impact plan performance for the 2023 measurement year (2025 Star Ratings). Plans should not be penalized for member enrollment changes during this additional SEP, as such election changes have no bearing on the plan's performance but are due solely to statutory changes established by the IRA. There are also circumstances where an enrollee with an existing plan may select another plan under the same MA organization because their care and benefit needs have changed. For example, a member may choose to move to a D-SNP within the same parent organization or move from a PDP to a MA-PD due to changing life circumstances. If a plan assists a beneficiary to move to a product that may be more appropriate for their situation, the change should be excluded from the Members Choosing to Leave the Plan measures. **We ask CMS to review and address the above issues that could impact plan performance on this Part C and Part D measure.**

TAB 13

PUBLIC SUBMISSION

As of: March 04, 2024
Received: February 13, 2023
Status: Posted
Posted: February 15, 2023
Category: Other Health Care Provider - HPA70
Tracking No. le3-8vzs-4uaa
Comments Due: February 13, 2023
Submission Type: Web

Docket: CMS-2022-0191
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024

Comment On: CMS-2022-0191-0001
Medicare Program: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, etc.

Document: CMS-2022-0191-0619
Comment on CMS-2022-0191-0001

Submitter Information

Email: federal_guidance@uhc.com
Organization: UnitedHealth Group

General Comment

See attached file(s)

Attachments

UHG Comments - MA CY 2024 Policy Changes

UNITEDHEALTH GROUP

9900 Bren Road East, MN000-T000,
Minnetonka, MN 55343

February 13, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted Electronically: www.regulations.gov

Re: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Proposed Rule (CMS-4201-P)

Dear Administrator Brooks-LaSure,

UnitedHealth Group (UHG) is pleased to respond to the Centers for Medicare and Medicaid Services (CMS) request for comments regarding the Contract Year 2024 Policy and Technical Changes to the Medicare Advantage (MA) and Medicare Prescription Drug Benefit (Part D) Programs Proposed Rule. We are focused on providing all Medicare beneficiaries with stable access to high-quality, affordable care and continuing to facilitate informed consumer decision-making, improving outcomes and quality, and advancing equitable health care. We believe CMS's recent actions will undermine the health care that seniors and individuals with disabilities enrolled in the MA and Part D programs receive. **We are concerned about the combined impact of the changes included in the Proposed Policy Rule, Risk Adjustment Data Validation (RADV) Final Rule, and the proposed 2.3% decrease in overall MA rates for 2024. CMS is making a significant departure from current policy that we believe will drive up premiums and cut benefits for MA beneficiaries.**

UnitedHealth Group is a mission-driven organization dedicated to helping people live healthier lives and helping our health care system work better for everyone through two distinct business platforms - UnitedHealthcare, our health benefits business, and Optum, our health services business. Our workforce of 380,000 people serves the health care needs of 149 million people worldwide, funding and arranging health care on behalf of individuals, employers, and the government. We not only serve as one of the nation's most progressive health care delivery organizations, we also serve people within many of the country's most respected employers, in Medicare serving nearly one in five seniors nationwide, and in Medicaid supporting underserved communities in 32 states and the District of Columbia.

MA delivers significantly lower out-of-pocket costs for beneficiaries and provides more comprehensive and coordinated benefits that work to achieve better health outcomes, while serving a more diverse, lower-income, and clinically complex population compared to Medicare Fee-For-Service (FFS). Beneficiaries also report a 94% satisfaction rate with the MA program.[1] Overall,

[1] Morning Consult, Annual Seniors on Medicare Survey, January 2022. Available at: https://bettermedicarealliance.org/wp-content/uploads/2022/01/BMA_Seniors-on-Medicare-Memo_final3.pdf

research suggests that MA achieves a 12% savings to the health system when combining both beneficiary and government savings.[2] MA has an established track record of delivering better health outcomes for people compared to those in Medicare FFS, with a more than 40% lower rate of avoidable hospitalizations.[3]

UHG's MA offerings are consumer-focused, helping beneficiaries find the best paths of care at the right place and time, while also reducing health care costs through modernized and coordinated clinical programs and resources that address their unique needs. We are driving innovation to promote person-centered care through clinical models focused on value-based care, resulting in 80% of our MA members obtaining services from providers in value-based arrangements. A recent, first-of-its-kind study in *JAMA* found MA patients served by Optum value-based care experienced 18% lower odds of an inpatient admission, 11% lower odds of emergency department (ED) visits, and 44% reduction in hospital admissions for COPD or asthma complications.[4] We are working to advance health equity through innovative programs that proactively identify and treat chronic and acute conditions, as well as address Social Determinants of Health (SDOH). For example, we are striving to better address food and nutritional needs and improve continuity of care by offering 14 meals after each inpatient stay during the plan year.

We appreciate the opportunity to provide feedback on specific policy changes to help CMS build upon the successes of the MA program. As CMS finalizes policies for 2024, UHG recommends the agency prioritize the following specific adjustments:

- Preserve the Improvement Hold Harmless Provision in the Star Ratings Program to ensure benefit stability and continued investments in supplemental benefits focused on addressing SDOH.
- Include both the Health Equity Index and the Reward Factor in the Star Ratings Program until CMS can ensure accuracy on social risk factor data.
- Uphold CMS's longstanding policy regarding when a beneficiary should be considered an inpatient for purposes of correct Medicare billing (the "2-Midnight Rule").[5]
- Maintain the current definition of Gross Covered Prescription Drug Costs to ensure effective implementation of the Inflation Reduction Act.
- Follow the plain language of the Patient Protection and Affordable Care Act and adopt the correct standard that an MA plan or Part D sponsor has “identified” an overpayment once it has determined that the overpayment exists.

---

[2] Milliman, Value to the Federal Government of Medicare Advantage, October 2021. Available at: https://bettermedicarealliance.org/publication/milliman-reportvalue-to-the-federal-government-of-medicare-advantage/

[3] Center for Innovation in Medicare Advantage, Positive Outcomes for High-Need, High-Cost Beneficiaries in Medicare Advantage Compared to Traditional FFS Medicare, December 2020. Available at: https://bettermedicarealliance.org/wp-content/uploads/2020/12/BMA-High-Need-Report.pdf

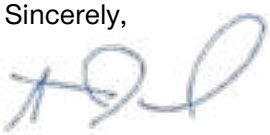
[4] JAMA. Comparison of Care Quality Metrics in 2-Sided Risk Medicare Advantage vs Fee-for-Service Medicare Programs. December 2022. Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2799376?trk=public_post_comment-text

[5] See CMS, 78 FR 50495, 50943 (Aug. 19, 2013) (Final Rule) (discussing the 2-midnight rule as clarification to address "hospital claim errors... due to inappropriate patient status (that is, the services furnished were reasonable and necessary, but should have been furnished on a hospital outpatient, rather than hospital inpatient, basis).

As CMS considers policy changes in MA, we urge CMS to ensure any finalized payment and policymaking does not compromise the access, affordability, comprehensive benefits, and care coordination programs that MA beneficiaries currently receive and depend on as they age.

Attached are UHG's technical comments and recommendations in response to the CMS 2024 MA and Part D Policy Proposed Rule. UHG appreciates this opportunity to provide comments, and if you have any questions, please do not hesitate to contact me.

Sincerely,



Tim Noel, CEO
UnitedHealthcare, Medicare & Retirement

Table of Contents

III. Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Programs 5

A. Health Equity in Medicare Advantage (§§ 422.111, 422.112, and 422.152) 5

B. Behavioral Health in Medicare Advantage (§§ 422.112, 422.113, and 422.116) 5

D. Enrollee Notification Requirements for MA Provider Contract Terminations (§§ 422.111 and 422.2267) 7

E. Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (§§ 422.101, 422.112, 422.137, and 422.138) 8

F. Request for Comment on the Rewards and Incentives Program Regulations for Part C Enrollees (§ 422.134 and Subpart V) 19

H. Review of Medical Necessity Decisions by a Physician or Other Health Care Professional with Expertise in the Field of Medicine Appropriate to the Requested Service and Technical Correction to Effectuation Requirements for Standard Payment Reconsiderations (§§ 422.566, 422.590, and 422.629) 21

N. Clarify Language Related to Submission of a Valid Application (§422.502 and § 423.503) 21

O. Updating Translation Standards for Required Materials and Content (§§ 422.2267 and 423.2267) 22

P. Medicare Advantage and Part D Marketing (Subpart V of Parts 422 and 423) 23

R. Part D Medication Therapy Management (MTM) Program (§ 423.153(d)) 29

V. Limitation on PDP Contracts Held by Subsidiaries of the Same Parent (§ 423.272) 31

W. Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act (§§ 422.326(c), 423.360(c), (§401.305(a)(2)) 32

IV. Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies 35

U. Shortages of Formulary Drug Products During a Plan Year (§ 423.120) 35

AA. Part D Proposed Automatic Shipment Requirements (§ 423.505) 36

AC. Application of 2-Year Ban on Reentering the Part D Program Following Non-Renewal (§§ 423.507 and 423.508) 37

AD. Crosswalk Requirements for Prescription Drug Plans (§ 423.530) 38

AH. Gross Covered Prescription Drug Costs (§423.308) 38

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System .. 39

D. Adding, Updating, and Removing Measures (§§ 422.164 and 423.184) 40

E. Measure Weights (§§ 422.166(e) and 423.186(e)) 43

F. Guardrails (§§ 422.166(a)(2)(i) and 423.186(a)(2)(i)) 43

G. Health Equity Index Reward (§§ 422.166(f)(3) and 423.186(f)(3)) 43

H. Improvement Measure Hold Harmless (§§ 422.166(g)(1) and 423.186(g)(1)) 45

III. Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

A. Health Equity in Medicare Advantage (§§ 422.111, 422.112, and 422.152)

Medicare Advantage Provider Directories (§ 422.111)

UHG supports the proposed codification of current guidance that Medicare Advantage (MA) plans identify the provider's cultural and linguistic capabilities, including languages spoken and access to interpretative services, in their provider directories.

However, UHG requests that CMS reconsider the proposed requirement to identify providers who have a waiver to treat patients with medications for opioid use disorder (MOUD). Recent action by the Drug Enforcement Agency (DEA), as well as pending rulemaking from the DEA and the Substance Abuse and Mental Health Services Administration (SAMHSA) could modify opioid treatment program qualifications and requirements and the special registration and waiver rules for providers engaged in the treatment of opioid use disorders (OUDs). While the scope of the expected changes to provider qualifications and permitting is unknown in the pending guidance, UHG urges CMS to consider delaying additional provider directory requirements targeted at identifying providers with a waiver until further DEA and SAMHSA guidance is issued and there is clarity about the impacted population of providers and portion of plan networks for which this special designation may be required.

B. Behavioral Health in Medicare Advantage (§§ 422.112, 422.113, and 422.116)

Behavioral Health Specialties in Medicare Advantage Networks (§§ 422.112 and 422.116)

UHG opposes CMS's proposal to add prescribers of MOUD to the list of provider-specialty types subject to network adequacy evaluation. As previously discussed, DEA regulation of these specialty providers is currently changing. Additionally, there are data accuracy issues currently with the source MA plans rely on to determine whether a treatment facility, program or provider meets the HHS qualifications for certification as an Opioid Treatment Program (OTP). CMS maintains the list of approved OTPs that plans must use to contract, credential, and conduct business with OTPs. UHG has observed numerous issues with the accuracy and timeliness of the information on the CMS website, which has led to beneficiary and provider complaints and claims denials. Until these data accuracy issues are remediated, MA plans should not have a specific network adequacy standard applied to them because they could inadvertently fail to meet it based on the use of inaccurate data completely out of their control. Accordingly, UHG urges CMS to delay this proposal until the data integrity issues have been adequately addressed.

UHG also has concerns with the proposed time and distance standards and minimum number of in-person providers in each county type proposed for prescribers of MOUD (including MOUD Waivered Providers and OTPs). The proposed standards do not account for the scarcity of these providers. For example, it does not make sense to have the same maximum time standard for social workers

and prescribers of MOUD in the metropolitan category given the material difference in the number of such providers in these categories. UHG urges CMS to reconsider the proposed standards to ensure MA plans can comply with them given the current available workforce that meet the definitions of these categories.

UHG recommends CMS consider modifying the existing specialty provider type of "psychiatrists" to include not just psychiatrists but any qualified provider who can prescribe prescription drugs used to treat behavioral health conditions within the scope of their practice under state law. For example, the category could include advance practice clinicians such as advance practice registered nurses, nurse practitioners, physician assistants, as well as psychologists, who have prescribing authority under their state licensing and scope of practice requirements. We believe broadening this provider type would expand access for beneficiaries and allow them to obtain medications from additional providers with a behavioral health specialty.

Finally, UHG supports the proposal to include the behavioral health specialty types in the list of provider types for which the 10 percent credit to time and distance standards applies and appreciates the recognition of the vital nature of behavioral health telehealth services as a critical tool to meet consumer access and care needs.

Behavioral Health Services in Medicare Advantage (§§ 422.112 and 422.113)

UHG supports the proposal to clarify that the definition of an "emergency medical condition" includes conditions arising from a behavioral health or substance use disorder diagnosis. It is important to note that in the context of behavioral health services, there are services which are designated as "crisis services," and that in some cases these services will be the result of an emergency medical condition and in other cases they will not. As such, UHG cautions against defining "emergency medical condition" with reference to "conditions for which an enrollee may receive behavioral health crisis services." It is our understanding that SAMHSA is leading an interagency work group to collaborate on more clearly defining "crisis services," and this work may impact this proposal and future guidance on this topic.

Medicare Advantage Access to Services: Appointment Wait Time Standards (§ 422.112)

CMS proposes to codify the standards for appointment wait times for primary care services that are currently set forth in the Medicare Managed Care Manual and to extend those standards to behavioral health services. UHG urges CMS to set the requirement for services which are "not emergency or urgently needed" to be 14 calendar days rather than within one week as proposed. A one-week standard for non-emergent care would make it harder for providers to prioritize access for urgently needed care, which commonly requires access within 72 hours. This is especially true in geographic areas with health care work force issues or specialties, like behavioral health, with provider shortages.

To reduce administrative burden and avoid creating standards that would foster disparities across payer types, UHG also supports efforts to reference alternative standards that may already exist and appropriately apply to MA plans. As an example, UHG supports alignment of standards for wait

times across Qualified Health Plans (QHP) and MA plans or consideration of non-payer specific standards such as standards promoted by NCQA.

CMS solicits comment on whether a more flexible approach would be appropriate, such as requiring MA plans to have specific appointment wait time standards in their written internal policies and requiring MA plans to meet the specific appointment wait time limits for routine or non-emergency services only for a significant portion of appointments. UHG supports this approach because access and wait time for any given beneficiary may be influenced by factors beyond the plan's control and believes that CMS's proposed 95 percent standard for compliance is appropriate.

D. Enrollee Notification Requirements for MA Provider Contract Terminations (§§ 422.111 and 422.2267)

CMS proposes adding specific and more stringent beneficiary notification requirements for provider contract terminations that involve behavioral health and primary care providers. Specifically, CMS proposes that plans notify all enrollees who have ever seen a terminating behavioral health or primary care provider, not just enrollees who are seen on a regular basis by the terminating provider, which is the case for other specialty types. While UHG appreciates CMS's commitment to removing barriers to behavioral health services, CMS does not provide any indication that the current notification processes are deficient and causing continuity of care issues for enrollees or dissatisfaction. Indeed, the existing notification processes are consistent with industry standards and practices, and UHG does not believe changes are necessary. Accordingly, UHG recommends CMS only require MA plans to notify eligible enrollees who are assigned to a terminating primary care provider or have seen the behavioral health provider or primary care provider in the past twelve months. Requiring plans to notify all enrollees who have ever received care from the terminating provider without any reasonable "look back" period to identify impacted patients could cause confusion if the enrollee saw the provider for a limited time or a significant length of time in the past.

CMS also proposes requiring MA plans to provide notice to enrollees of a terminating behavioral health or primary care provider 45 calendar days prior to the termination instead of 30 calendar days for other provider types. Adding an additional 15 days to the industry standard 30 days will increase the likelihood of beneficiary and provider abrasion, as often contract negotiations continue through the last month of the contract. Informing beneficiaries their provider is terminating when that might not ultimately happen, can be unnecessarily disruptive and confusing. An earlier notification timeline increases the likelihood that more beneficiaries will be in a situation where they are notified of a contract termination that does not occur and as a result would need to be re-notified that the provider is remaining in network. An earlier and premature notification may also negatively impact the MA plan's ability to successfully negotiate a resolution and provide continuity for its beneficiaries. UHG recommends instead CMS maintain its requirement to notify eligible enrollees 30 calendar days prior to the termination, with the below exceptions:

- When the provider does not notify the MA plan of their intent to terminate with time to provide 30 days of notice.
- When the provider and health plan are in active negotiations.

UHG also opposes CMS's proposal to notify all enrollees who have seen a terminating behavioral health or primary care provider telephonically in addition to sending a written communication via US Mail. CMS has not indicated that the existing notification processes are problematic. Accordingly, adding this duplicative telephonic notification requirement does not seem necessary. In addition, UHG requests that CMS include an option for MA plans to provide the written communication through electronic delivery if the beneficiary has opted into e-delivery. Electronic delivery ensures the beneficiary receives the information in the timeliest manner and through the delivery method elected by the beneficiary as their preference.

Finally, CMS proposes requiring MA plans to include specific content in the provider termination notices, including names and phone numbers of in-network providers the enrollee may access. Providing this information could be confusing to enrollees because they may think that these are the only providers they can access. Similarly, enrollees may mistakenly believe the MA plan recommends these providers based on enrollees' language(s) spoken, location, accessibility, gender, or other factors. UHG recommends that instead of requiring MA plans to include specific names and phone numbers of in-network providers, CMS require the notice contain information on how an enrollee can access the MA plan's online provider directory or request a paper directory from the MA plan.

UHG does support the development of a model notice document by CMS with review and input from stakeholders. UHG recommends CMS consider existing notices of this type required for commercial plans to promote consistency to the greatest extent possible in such notices.

E. Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (§§ 422.101, 422.112, 422.137, and 422.138)

Taken as a whole, CMS's proposed changes could significantly undercut MA plans' ability to ensure access to medically necessary care while limiting waste, inefficiency, and risk of beneficiary harm from unnecessary and unproven services. The Social Security Act expressly references MA plans' ability to establish utilization management procedures,[6] such as "prior authorization or other review requirements,"[7] intentionally leaving room for innovation in utilization management tools and care management strategies. However, CMS's proposals markedly deviate from Congress' intent in creating Medicare managed care because they substantially limit MA plans' ability to actually manage care.

Utilization management tools are critical to MA plans' ability to ensure access to high quality safe care and maintain high member satisfaction while appropriately managing costs. In 2022, MA-PD plans received an average rating of 4.37 out of 5 when assessed on more than 30 measures across clinical and patient experience areas as part of CMS's robust quality rating system for MA plans.[8]

[6] Social Security Act, § 1852(c)(2)(B).
[7] Social Security Act, §§ 1852(c)(1)(G).
[8] Better Medicare Alliance, State of Medicare Advantage (July 2022), available at: https://bettermedicarealliance.org/wp-content/uploads/2022/07/BMA-State-of-MA-2022-FIN.pdf.

Further, nine in ten seniors agree that Medicare Advantage lets them see the doctors they want on their own terms (88%) and saves them money compared to other coverage options (89%).[9] Nearly all (94%) seniors with MA plans are satisfied with their Medicare Advantage coverage.[10] Through utilization management tools and other flexibilities that Congress built into the role of Coordinated Care Plans, Medicare Advantage provides $32.5 billion annually in additional value to beneficiaries and the federal government and provides all Medicare-covered benefits for 24% less than FFS Medicare.[11]

UHG is committed to providing Medicare Advantage beneficiaries with timely access to high-quality care and continuing investments in technology and processes that streamline coverage reviews, case management, and care coordination. For these reasons, UHG supports many aspects of the proposed rule; however, some of the proposed changes (§§ 422.101, 422.112, and 422.137) contain elements counter-productive to timely and appropriate access, transparency, and quality while simultaneously increasing costs to the Medicare Trust Funds. Detailed comments are set forth below.[12]

Coverage Criteria for Basic Benefits (§ 422.101)

UHG supports codification of longstanding CMS guidance that MA plans must make coverage determinations based on medical necessity, and in making those determinations, may apply internal policies that include coverage criteria that are consistent with and no more restrictive than traditional Medicare. Departing from existing policy, CMS proposes to limit MA plans' ability to use internal coverage criteria.[13] CMS focuses on partial stakeholder feedback and limited findings in the April 2022 OIG report to support its proposal.[14] CMS's rationale does not take into account: (1) the benefits of and need for evidence-based tools when making clinical judgments; (2) prevailing evidence of MA health plan quality; and (3) high enrollee satisfaction.

Requirements Relating to Basic Benefits

[9] Memo to Better Medicare Alliance, Survey Results: Annual Seniors on Medicare Survey (2022), available at: https://bettermedicarealliance.org/wp-content/uploads/2022/01/BMA_Seniors-on-Medicare-Memo_final3.pdf.
[10] Id.
[11] Better Medicare Alliance, State of Medicare Advantage (July 2022), available at: https://bettermedicarealliance.org/wp-content/uploads/2022/07/BMA-State-of-MA-2022-FIN.pdf.
[12] Prior to finalizing any of the proposed changes to §§ 422.101, 422.112, 422.137, and 422.138, CMS must publish a regulatory impact analysis so that stakeholders can better understand the exact changes CMS is purportedly making and provide public comment on them.
[13] Proposed § 422.101(c)(1)(i)(A).
[14] CMS explains that proposed changes at 422.101(b) and (c) are based on certain stakeholder feedback and OIG recommendations. Proposed Rule, 79499. While the OIG report is concerning, it also found that MA plans approve the "vast majority of prior authorization requests and provider payment requests." The report data also showed that nearly 90% of prior authorization denials were appropriate, meaning the treatment or service that was requested was either not in line with evidence-based care, was unnecessary, or even potentially harmful. Additionally, the OIG acknowledged that the results of its case review were subject to the interpretations and clinical judgments of its health care coding experts and physician reviewers. The OIG noted that results would likely have been different under Traditional Medicare. OIG, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, April 2022.

CMS proposes to amend § 422.101(b)(2) to clarify that MA plans must comply with general coverage and benefit conditions in Traditional Medicare laws, unless superseded by laws applicable to MA plans. The proposed revision also includes references to specific Traditional Medicare regulations that include payment criteria for Part A inpatient admissions, skilled nursing facility (SNF) care, home health services, and inpatient rehabilitation facilities (IRF). CMS also proposes to add subsection (6) to §422.101(b) to allow MA plans to create internal coverage criteria based on widely used treatment guidelines or clinical literature where coverage criteria are not fully established in "applicable Medicare statute, regulation, NCD or LCD." Finally, CMS proposes parameters for medical necessity determinations in §422.101(c), including that MA plans may not deny coverage for basic benefits based on coverage criteria not specified in the section. UHG opposes any interpretation of the new regulatory language that limits an MA plan's ability to adequately assess whether a covered item or service is medically necessary or that would prohibit use of internal coverage criteria when appropriate and consistent with traditional Medicare coverage requirements.

2-Midnight Rule

Specifically, UHG opposes the proposed reference to § 412.3, Part A inpatient admissions, in § 422.101(b)(2) if it is intended to mean that MA plans are limited to the treating physician's presumption that a member requires a two midnight stay as the only criteria for determining whether an inpatient stay is reasonable and necessary. § 412.3 contains CMS's requirements for determining when a beneficiary should be considered an inpatient for purposes of correct Medicare billing (the "2-Midnight Rule").[15] In the Final Rule adopting § 412.3, CMS explained that the 2-Midnight Rule does not determine whether services are "reasonable and necessary"[16] or the appropriate level of care, because "there are no prohibitions against a patient receiving any individual service as either an inpatient or an outpatient, except for those services designated by the... Inpatient-Only list."[17]

CMS should clarify that the treating physician's presumption that an inpatient stay will cross two midnights is not the only criteria for determining whether an inpatient stay was reasonable and necessary. Rather, CMS should make clear that § 412.3 allows for case management review of inpatient admissions based on whether the complex medical factors documented in the medical record support medical necessity of the inpatient admission, regardless of the actual duration of the hospital stay.[18] As further discussed below, this clarification is consistent with MA plans long-

[15] See CMS, 78 FR 50495, 50943 (Aug. 19, 2013) (Final Rule) (discussing the 2-midnight rule as clarification to address "hospital claim errors… due to inappropriate patient status (that is, the services furnished were reasonable and necessary, but should have been furnished on a hospital outpatient, rather than hospital inpatient, basis)." If CMS finalizes proposed § 422.101(b)(2) with reference to § 412.3, CMS should explain the basis for its re-interpretation of the 2-Midnight Rule as a coverage rather than payment rule.

[16] See id. at 50951 ("We note it was not our intent to suggest that a 2-midnight stay was presumptive evidence that the stay at the hospital was necessary; rather, only that if the stay was necessary, it was appropriately provided as an inpatient stay.")

[17] Id. at 50945.

[18] CMS, 78 FR 50495, 50944 (Aug. 19, 2013) (Final Rule) ("…a reasonable expectation of a stay crossing 2 midnights, which is based on complex medical factors and is documented in the medical record, will provide the justification needed to support medical necessity of the inpatient admission, regardless of the actual duration of the hospital stay and whether it ultimately crosses 2 midnights.") Note also, § 412.3(d)(3), with regard to inpatient stays not

standing ability to develop criteria for whether services are reasonable and necessary when Traditional Medicare criteria are not fully established.

"Fully Established" Coverage Criteria

UHG recognizes that MA plans must make coverage determinations consistent with the requirements set forth in Medicare laws and regulations. But even relatively specific coverage requirements in Medicare laws and regulations lack objective criteria outlining the specific clinical information necessary to meet coverage requirements. UHG recommends that CMS revise proposed § 422.101(b)(6) to state: "When coverage criteria are not fully established in applicable NCD and/or LCD, MA organizations may...." This change would clarify that coverage criteria are not "fully established" when found in Medicare statute and regulation alone. Rather, coverage criteria for a particular service may be fully established only if there is also an applicable NCD or LCD (or both).

Even then, as CMS notes, some NCDs and LCDs include flexibility that allows for coverage in circumstances beyond the specific coverage or non-coverage indications that are listed in the NCD or LCD.[19] Likewise, some NCDs and LCDs expressly acknowledge that additional, unspecified coverage criteria may be applied to determine medical necessity in a particular case.[20] In these situations, UHG agrees that Medicare coverage criteria are not fully established and MA plans may also apply internal coverage criteria.

UHG also recommends striking that MA plans "may not deny coverage for basic benefits on coverage criteria not specified in paragraph (b) or (c) of this section."[21] Coverage requirements in Medicare statute and regulation often expressly acknowledge that additional, unspecified criteria need to be applied to determine medical necessity in a particular case. Even substantive requirements for acute hospital and post-acute care, for example, involve inexact standards about "reasonable expectations" and "reasonable and necessary."

To illustrate, IRF services are covered when there is a "reasonable expectation" that the patient meets certain coverage criteria, including that the patient "requires" multiple therapy disciplines and can "reasonably be expected" to benefit from an "intensive" rehabilitation program.[22] CMS guidance explains that "the intensity of therapy provided must be reasonable and necessary under section 1862(a)(1)(A) of the Act and must never exceed the patient's level of need or tolerance, or

---

expected to cross two midnights, requires a reasonable and necessary determination on a case-by-case basis using a list of non-exhaustive factors. A similar case by case assessment in the context of stays crossing two midnights is aligned with this provision.

[19] Proposed Rule at 79500. See, e.g., Electrocardiographic Services NCD 20.15 ("Certain uses other than those specified above may be covered if, in the judgment of the local Medicare Administrative Contractor (MAC), such use is medically necessary.").

[20] Proposed Rule at 79502 (discussing Computed Tomography NCD 220.1). NCD 220.1 states that a CT scan must be found reasonable and necessary considering the patient's symptoms and preliminary diagnosis, as well as reasonable and necessary as the initial diagnostic test, if applicable. The NCD does not specify the criteria to be applied to determine whether a CT scan is reasonable and necessary as a diagnostic test or as the initial diagnostic test.

[21] § 422.101(c)((1)(i)(A).

[22] § 412.622(a)(3).

compromise the patient's safety."[23] Given these imprecise requirements, additional coverage criteria are necessary to ensure appropriate and consistent determinations.

Permitting use of internal coverage criteria, as needed, to help support and better define the Medicare coverage criteria in statute, regulation, and NCD or LCD (if applicable) promotes consistent, transparent, and evidence-based clinical decisions.

Medical Necessity Determinations

CMS previously stated: "[T]here is a distinction between the general rule that a health care service is covered under Medicare and the decision that an individual patient fits the clinical criteria necessary for receipt of the service."[24] UHG agrees with this statement.

UHG supports the use of evidence-based clinical appropriateness tools to assist clinical reviewers in applying Traditional Medicare coverage requirements to specific clinical facts and circumstances. When a coverage requirement is expressed in terms other than the presence or absence of specific clinical factors, CMS should encourage the use of national best practices and evidence-based guidelines to identify the relevant clinical information necessary to assist the reviewer in making clinical determinations.

CMS should clarify that use of such tools does not equate to an MA plan applying additional criteria beyond Traditional Medicare, but rather complements and helps interpret existing Medicare requirements. In fact, CMS Medicare review contractors use similar resources to assist in their review decisions. In the FY 2014 IPPS/LTCH PPS Final Rule, CMS explains: "Medicare review contractors must abide by CMS policies in conducting payment determinations, but are permitted to take into account evidence-based guidelines or commercial utilization tools that may aid such a decision."[25] That CMS allows Medicare review contractors to use evidence-based guidelines indicates CMS recognition of such guidelines as an appropriate tool to assist reviewers in determining coverage consistent with Traditional Medicare requirements.

Proposed Standard: Current Evidence in Widely Used Treatment Guidelines and Clinical Literature

UHG supports the revised standard for clinical evidence as provided in 422.101(b)(6) with a clarification—express inclusion of the ability for MA plans to use third-party evidence based clinical criteria. UHG asks CMS to expressly recognize third-party, evidence-based clinical appropriateness guidelines, such as InterQual® criteria, as a source of medical evidence to support the interpretations and clinical judgment of the reviewing professional.

Tools such as InterQual® have been developed to provide objective, evidence-based criteria that align with Medicare requirements for coverage of acute hospital, SNF, home health, and IRF services (among others). Using evidence-based criteria aligned to Medicare coverage guidelines helps MA plans ensure appropriate and consistent decisions about whether services would be covered under Traditional Medicare.

[23] CMS, Medicare Benefit Policy Manual, Ch. 1, § 110.2.2.
[24] CMS, 65 FR 40107, 40207 (June 29, 2000) (Final Rule).
[25] CMS, 78 FR 50495, 50948 (Aug. 19, 2013) (Final Rule).

Proposed Policy Reversal: Managing Care Delivery

UHG opposes CMS reversing longstanding policy to restrict MA plans' ability to manage the provision of services when care can be delivered in more than one way or in more than one type of setting. UHG supports CMS's prior position that the requirement under § 422.101(a) to provide coverage for all Medicare covered services "is not intended to dictate care delivery approaches for a particular service."[26]

UHG questions the discussion in the preamble that Traditional Medicare allows coverage for SNF and IRF when the beneficiary's needs could have been met in a different setting.[27] CMS statements in the proposed rule directly contradict its Medicare Benefit Policy Manual instructions that provide:

> In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in a SNF on an inpatient basis, the A/B MAC (A) considers the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services.[28]
>
> The IRF benefit is not appropriate for patients who have completed their full course of treatment in the referring hospital, but do not require intensive rehabilitation. Medicare benefits are available for such patients in a less-intensive setting.[29]

Medically managing setting of care is essential to making appropriate determinations for acute and post-acute care based on Traditional Medicare coverage requirements. As illustrated by the examples above, CMS has long interpreted "reasonable and necessary" under Section 1862 to contemplate whether alternative settings or types of providers are able to meet the beneficiary's needs.

More recent CMS actions to expand the settings Medicare will provide coverage for services historically only covered in a hospital setting further supports allowing MA plans the ability to manage care to those settings to provide better care for members as well as ease hospital bed and nurse staffing shortages. During the onset and height of the pandemic, CMS took proactive steps to increase hospital capacity by allowing MA plans to approve care provided outside the traditional hospital setting: expanding the availability of telehealth services, allowing acute hospital at home services for members who met criteria for inpatient hospitalization but could be safely treated at home, and updating staffing flexibility to allow ambulatory surgical centers to provide greater inpatient care when needed.[30]

---

[26] CMS, 65 FR 40107, 40207 (June 29, 2000) (Final Rule).
[27] See, e.g., Proposed Rule at 79502.
[28] CMS, Medicare Benefit Policy Manual, Ch. 8, § 30.7.
[29] CMS, Medicare Benefit Policy Manual, Ch. 1, § 110.
[30] November 25, 2020: CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge (CMS.gov).

This same flexibility is currently being used to help address the influx of hospitalizations stemming from the combination of influenza, COVID-19 and RSV, and has proven to be a significant benefit to both members and providers. CMS's expansion of the settings for beneficiaries to obtain care only underscores the fact that enrollees can obtain the same level of care in different settings. CMS should not now limit MA plans from doing exactly what Congress intended they do, i.e., manage care. Narrowing the longstanding policy allowing medical management of type of setting conflicts with the requirement that MA plans only cover services that are "reasonable and necessary," is inconsistent with recent CMS actions and could impact needed flexibility in care management when our health system is in crisis.

Appropriate Use of Prior Authorization (§ 422.138)

UHG supports proposed § 422.138, including the codification of longstanding guidance that when an MA plan approves a pre-service determination of coverage, the plan cannot later deny coverage or payment of the approved item or service based on medical necessity. But we reiterate our comments to the requirements on basic benefits in proposed § 422.101, because § 422.138 expressly incorporates the standards specified in proposed § 422.101.

Continuity of Care

Access to Services

UHG is committed to providing Medicare beneficiaries with timely access to high-quality care and supports MA plans' ability to use prior authorization and case management to ensure access to medically necessary care. But UHG opposes approving a prior authorization for the duration of a prescribed order or ordered course of treatment when medical necessity can only be determined at a particular point in time. To avoid unintended consequences, UHG urges CMS to narrow its approach which goes far beyond the stated purpose of restricting unreasonable interference with provider care.

Requiring MA plans to cover services for periods of time or units of service beyond what can be determined at the onset of services conflicts with MA plans' obligations to ensure access to medically necessary care and impedes MA plans' ability to manage care through strategies that ensure quality and control unnecessary cost. Providers and patients are not required to design treatment plans according to standards and criteria for Medicare coverage or even evidence-based care guidelines. Even when treatment meets medical necessity coverage criteria upon initial review, the member's condition could change during the prescribed timeframe resulting in medical necessity criteria no longer being met. Given the variability of individual patients' responses to care, predicting length of stay or duration of need at the onset of services is difficult, if not impossible.

Instead, services should be authorized for a defined duration or specific number of visits which enables MA plans to manage cases and collaborate with providers to ensure that member needs are met and to timely facilitate any transitions to alternate levels of care. For instance, during facility bed shortages, this frees up capacity and enables access to inpatient services for patients who might not otherwise be admitted. The proposed rule's requirement to cover services for the duration of the

course of treatment is not necessary to ensure timely member access to medically necessary care.

"Active Course of Treatment"

UHG agrees that MA plans must allow new plan enrollees undergoing an active course of treatment for certain conditions or receiving inpatient care a reasonable transition period within which to request and receive any prior authorization applicable to that course of treatment. However, the proposed rule's definition of "active course of treatment"[31] conflicts with existing regulations. CMS should narrow the definition of "active course of treatment" to align with industry standards, which means: (1) a course of treatment for a serious and complex condition, which includes a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or a condition that is life threatening, potentially disabling, degenerative, or congenital, and requires specialized medical care over a prolonged period of time; (2) course of institutional or inpatient care; (3) scheduled nonelective surgery, including related postoperative care; (4) a course of treatment for a pregnancy; and (5) treatment for a terminal illness.

Adopting this definition aligns with industry standards and other federal continuity of care requirements while protecting beneficiaries who are at risk of negative outcomes from potential delays or interruptions in ongoing care.

90-Day Transition of Care

UHG supports efforts to ensure that beneficiaries receiving an active course of treatment experience no delays or disruptions in their treatment when enrolling in a new MA plan. UHG recommends modifying § 422.112(b)(8)(i)(B) to require MA plans to provide continued coverage for an active course of treatment authorized by the member's prior plan for the remainder of the authorized period or units of service. For courses of treatment scheduled or initiated prior to a member's transition date but not reviewed and authorized as medically necessary by the member's prior plan, MA plans should allow a maximum 30-day, as opposed to 90-day, transition period before requiring authorization for the services.

Allowing new members to avoid an initial or re-authorization of services for 90 days could lead to unnecessary and costly utilization without any evidence of member benefit. For new members receiving inpatient services, a 90-day transition would impede an MA plan's ability to conduct case management and coordinate services. To illustrate, concurrent review throughout an inpatient stay assists with successful discharge planning and allows MA plans to manage the length of stay by determining when the member no longer meets acute inpatient criteria and can be safely transferred to a lower level of care. Delaying concurrent review for 90 days could potentially lead to unnecessary resource utilization and lengthy hospitalizations. Applying a maximum of 30 days for a transition period would enable members to continue care while allowing MA plans to ensure the medical necessity of the ongoing services and assist with care coordination.

[31] § 422.112(b)(8)(ii)(B) defines active course of treatment as a course of treatment in which a patient is actively seeing a provider and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.

CMS intends proposed § 422.112(b)(8)(i)(B) to mirror Part D transition requirements, thereby enabling consistency between programs. However, a 90-day minimum transition period significantly exceeds Part D transition requirements at § 423.120, which require providing new members only up to a 30-day supply if requested within 90 days of coverage under a new plan.[32] Moreover, medical services present unique considerations compared to Part D drugs, such as the impact on case management and care coordination. For example, lengthy hospitalizations could result in coverage of custodial care which is not a benefit under Traditional Medicare and longer stays could potentially increase hospital associated infections and patient safety events which could have been prevented if the member had been moved to a lower level of care when acute inpatient care was deemed no longer medically necessary. In the post-acute scenario, prolonged stays when such care is not medically necessary could result in unwarranted exhaustion of members' benefits. Taking these factors into account, a 30-day transition period for new MA members is more aligned to Part D transition requirements.

Mandate Annual Review of Utilization Management (UM) Policies by a UM Committee (§ 422.137)

CMS proposes that an MA plan may not use any UM policies for basic or supplemental benefits unless those policies and procedures have been reviewed and approved by a UM committee. CMS believes that this would ensure that UM policies are reviewed on a timely basis and have the benefit of provider input. CMS states that proposed § 422.137 would establish a UM committee that would operate similar to the Pharmacy and Therapeutics (P&T) committee.

The proposed rule sets up a duplicative and potentially conflicting set of requirements which appears unnecessary. MA plans have existing medical management programs supported by existing medical management policies and procedures. Those policies and procedures are reviewed by existing UM committees and are led by practicing physicians. MA plan medical management programs are subject to NCQA standards[33] and audit. If CMS adopts a UM committee requirement, CMS should deem compliant with such requirements any MA plan that has NCQA health plan accreditation or meets NCQA health plan accreditation requirements. CMS should also clarify how proposed § 422.137 would apply when an MA plan has delegated utilization management functions, including whether and how the requirements of proposed § 422.137 would be shared or divided between the MA plan and its delegate(s).

Effective Date

If CMS finalizes a January 1, 2024, effective date, MA plans will have a relatively short period of time to meet the requirements to establish the new committee as well as to complete the following actions:

[32] A 91-day supply is allowed in long-term care settings.

[33] NCQA surveys include whether an organization satisfies requirements such as: maintains written UM program description that includes specified structural elements; conducts annual review of the UM program; maintains written UM criteria and written policies for appropriately applying the criteria; and senior level physician involvement in implementation, supervision, oversight, and evaluation of the UM program.

- Recruiting of committee members, including clinical specialists, which may be challenging given the substantial time commitment needed from members, and the shortage in many physician specialties.
- Drafting and execution of Independent Contractor agreements for purposes of committee membership.
- Reviewing potential conflicts of interest, including time to address and resolve such conflicts where possible.
- Implementing a process to re-review existing UM policies and procedures.

For these reasons, if CMS proceeds to finalize this requirement as proposed, CMS should delay the effective date to at least January 1, 2025.

UM Committee Membership

If CMS finalizes the rule as proposed, UHG generally supports a requirement for the UM committee to include a majority of members who are practicing physicians, including members representing various clinical specialties. UHG's existing committees consist of practicing physicians with licenses in various specialties using their medical license to conduct UM and other clinical and medical management related work for the MA plans.

UHG also generally supports a requirement that the participation of physicians on the Committee who are board-certified through the Board of Medical Specialists or ABMS. UHG recognizes the benefit of including other types of providers or other health care professionals in fields such as physical therapy, chiropractic care and integrative medicine, who have formal training and active certification in their specialty area.

However, proposed § 422.137(c) and (d) again sets up potentially duplicative and conflicting requirements and mismatches clinical subject matter expertise with responsibilities for medical management programs and regulatory compliance. UHG opposes combining review of medical management programs and policies with review of clinical criteria into a single committee. UHG has two separate committees to handle these substantive areas and UHG's robust committee structure is consistent and compliant with NCQA standards. Medical management processes and coverage criteria require different clinical subject matter expertise and are more effectively managed by two separate committees. Further, UM committee responsibilities should not include determinations of compliance with specific MA organization regulatory requirements.

UHG supports permitting MA plans to use one UM committee to serve multiple MA plans to reduce the administrative burden. Additionally, one UM committee increases transparency and consistency.[34]

Additional Areas for Consideration and Comment

[34] Service on P&T and UM Committees is a substantial time commitment. Individuals that accept this responsibility are often recognized experts in their specialty field and have significant clinical responsibilities. With several competing demands on their time, it may be challenging for these clinical leaders to serve on both P&T as well as UM Committee meetings as the proposed rule suggests.

Termination of Services in Post-Acute Care

UHG supports authorizing post-acute treatment in discrete increments to allow MA plans to assess members needs and progress to ensure ongoing medical necessity of care. UHG also supports MA plans' ability to immediately issue a new termination of services when a Quality Improvement Organization (QIO) reinstates coverage due to administrative reasons and not because the QIO has determined continued services are medically necessary. When QIO reinstatement is based on the medical necessity of continued skilled services, however, a new termination should not be issued until the MA plan has reassessed the member's skilled needs.

Authorizing Treatment in Discrete Increments

As CMS notes in the proposed rule, federal regulation outlines criteria for termination of services from home health agencies (HHAs), SNFs, and comprehensive outpatient rehabilitation facilities (CORFs) at 42 CFR § 422.624. The regulation explicitly acknowledges termination of coverage at the end of a course of treatment preauthorized in a "discrete increment."[35] Prior authorization in discrete increments allows MA plans to ensure ongoing medical necessity. Each incremental review serves as an opportunity to assess the member's needs and discuss the member's progress, while working toward a comprehensive discharge plan. Authorizing treatment in discrete increments is appropriate for specific services and is a critical tool for MA plans to ensure quality of care and appropriate utilization.

Given the variability of individual patients' responses to care, predicting length of stay or duration of need at the onset of services is difficult. Requiring MA plans to cover services for periods of time or units of service beyond what can be determined medically necessary at the time of the request conflicts with MA plans' obligations to ensure access to medically necessary care and impedes MA plans' ability to manage care through strategies that ensure quality and control unnecessary cost.

Timing of Termination of Services following QIO Reinstatement

CMS requests comment on whether, when coverage is reinstated based on a QIO decision, the enrollee should have more than the 2-day period from the date of the termination of services notice before coverage can be terminated again by the MA plan. CMS should distinguish between coverage reinstatements based on administrative reasons and reinstatements based on medical necessity determinations. UHG supports MA plans' ability to immediately issue a new termination when the QIO overturn is due to administrative reasons, such as when an incomplete or incorrect Notice of Medicare Non-Coverage (NOMNC) is issued or when insufficient information is submitted to the QIO for review. In such cases, the QIO does not reinstate based on a review that continued skilled services are medically necessary; therefore, a new NOMNC should be issued immediately with sufficient information provided to the QIO for review to validate the need for continued services. Where services are reinstated based on medical necessity for continued skilled intervention, MA plans should not issue a new termination until the plan has time to receive incremental updates and reassess the ongoing needs of the member, which in general takes at least five days.

[35] § 422.624(a)(2).

Gold Carding

UHG agrees that gold carding programs have the potential to be an effective tool for simplifying the prior authorization experience for care providers that consistently demonstrate adherence to evidence-based care. Currently, there is significant variability in gold carding programs in terms of the items and services that are covered and provider qualifications for participation. This variation causes confusion for providers and complicates implementation, tracking and claims payment for payers. In practice, gold carding presents complex issues, including ensuring patient safety, supporting program integrity, and promoting access to high-quality, lower cost care. Given the complexities, UHG suggests CMS works closely with stakeholders on any future gold carding efforts to best address consistency and alignment of programs across markets.

Addressing Vulnerabilities that can lead to Manual Review Errors and System Errors

UHG's compliance program has extensive measures and controls in place to improve claim processing accuracy and to monitor for manual review errors and system errors, including but not limited to, adhering to NCQA system control standards for both UM systems and appeals systems. Additionally, UHG supports increasing automation of prior authorization to decrease manual errors while increasing transparency, reducing decision-making delays, and simplifying the process.

F. Request for Comment on the Rewards and Incentives Program Regulations for Part C Enrollees (§ 422.134 and Subpart V)

We appreciate CMS's request for comments on potential Reward and Incentive (R&I) program revisions to clarify the definition of "cash equivalent" as the term is used in § 422.134. CMS notes that it intends to incorporate the OIG definition of "cash equivalent," which includes "gift cards offered by large retailers or online vendors that sell a wide variety of items (for example, big box stores)."

Since the inception of the MA R&I programs, CMS has allowed plans to offer rewards incentives to beneficiaries, including gift cards, provided they are not offered "in the form of cash or monetary rebates, including reduced cost-sharing or premiums" and, consistent with statutory prohibitions, they are not "redeemable for cash."[36] The guidance has otherwise encouraged plans that offer rewards in the form of gift cards to offer a choice of cards to beneficiaries to account for differences in enrollees' preference and accessibility of retailers.

In 2021, CMS finalized its rewards regulation adding a new restriction on "cash equivalents," to prohibit not only rewards items that can be "converted to cash," like a check, but also items that "can be used like cash, such as a general-purpose debit card." As CMS notes, the 2021 final rule did not mention gift cards from big box stores or discuss them in relation to the prohibition on cash equivalents in § 422.134(d)(2)(i). While CMS stated in rule commentary that it intended to adopt OIG's definition of "cash equivalents," the final rule did not specify a prohibition on big box retailer gift cards, but instead stated it would be permissible for plans to offer a card "that can be redeemed only at specific retailers or retail chains or for a specific category of items or services."[37]

[36] Section 100.5 Permissible Rewards and Incentives, Managed Care Manual (2016).
[37] § 422.134.

UHG urges CMS not to incorporate the OIG's restrictive definition of "cash equivalents," including big box retailer gift cards into the MA rewards program regulation. The OIG commentary cited by CMS regarding cash equivalents and big box retailer gift cards was not made in the context of rewards and incentive programs and should not be applied in a categorical manner for the MA program. Many of the OIG comments regarding cash equivalents relate to requirements applicable to regulatory safe harbors protecting items or services and in-kind supports provided to patients to promote access to care and care management.[38] To meet the requirements of the safe harbors, an item or service or in-kind support offered to a patient must facilitate access to care or care management. For example, transportation to a medical appointment or a gift card for healthy food purchases or a smoking cessation program might be permissible, but movie tickets would not because a movie ticket does not itself facilitate access to care. In that context, the OIG stated that offering gift cards to big box retailers would not qualify for safe harbor protection because the card would not be limited to promoting patient's access to care but could instead be diverted and used for purposes unrelated to accessing care.

Those OIG concerns are not applicable in the context of a program designed to provide rewards and incentives to enrollees in exchange for completing defined health-related activities. Unlike the items and services described in the OIG safe harbors, MA plan rewards and incentives are not intended to provide the means for enrollees to access a health-related activity; they are instead intended to reward enrollee completion of health-related activities. The purpose is to provide items that have sufficient value to enrollees to encourage their active participation in maintaining their health. In addition, CMS regulations specify detailed requirements for rewards programs, including a requirement that reward items may not have a value that exceeds the value of the health-related activity. In this context, the OIG's stated concern around diversion of funds to impermissible purposes or a concern that an enrollee may be rewarded too much or have too many options for using the rewards they earn is not applicable.

Indeed, the OIG commentary on the in-kind support safe harbor pointed out that while cash equivalents are not specifically protected by the access to care safe harbor, that does not mean that all programs offering them are per se unlawful. Rather, the specific circumstances of the programs would require further analysis.[39] The OIG offered several examples of incentives in conjunction with government-sponsored programs, including those overseen by CMS, noting that adherence to the requirements of these programs would be relevant factors in assessing them. OIG further acknowledged that such government-administered programs may or may not meet all requirements of the regulatory safe harbor, but that the safe harbor is there to protect qualifying supports furnished outside of a program administered and monitored by CMS.[40]

As a practical matter, UHG is also concerned that the OIG definition of cash equivalent is too vague, and its application would lead to arbitrary and inequitable results. Requiring that plans avoid gift cards to "big box" retailers that sell "a wide variety of items" without any further direction leaves plans to guess at how many items a retailer can offer without being considered a "big box," and

[38] See § 1001.952(ee) and § 1003.110(6); 85 FR 77684, 77789-77793 December 2, 2020; 81 FR 88368, December 7, 2016.
[39] 85 FR 77684 at 77791.
[40] 85 FR 77684 at 77792-93.

conversely, how many items and services a plan must therefore exclude from their retailer gift cards to be permitted. Prohibiting "big box" retailer gift cards while allowing gift cards for several specific retailers also creates arbitrary results. It would be permissible to provide gift cards covering a wide variety of consumer goods if they are offered in the form of individual retailer gift cards that each individually sell more limited categories of items and services, but potentially impermissible to provide a gift card to one or two larger retailers that offer the same scope of items and services under one roof. Big box retailers such as Walmart and Amazon may be a primary source of retail goods in less affluent or rural communities, and so categorically prohibiting them in MA rewards programs may have a disparate impact on marginalized communities and create equity concerns.

Rather than defining cash equivalent in terms of the scope of items that can be purchased, or arbitrary definitions of big box retailers, UHG recommends that CMS propose a clarifying definition of permissible reward items for public comment that would more clearly define the types of transactions CMS views as harmful in the context of a beneficiary health incentive and reward programs and require that plans exclude those types of purchases from their program. For example, consistent with the statutory prohibition on offering items in the form of cash or monetary rebates, CMS could require that plans ensure that their cards exclude banking, ATM and any other cash transactions. Similarly, CMS might consider restrictions on specified purchases for items that CMS views as inconsistent with the purpose of a beneficiary health incentive program, such as alcohol, tobacco, or firearms.

If CMS decides to make further revisions to the rewards regulation, UHG asks that CMS publish the specific proposal and allow further industry comment before making it final. UHG also asks that CMS provide an effective date that allows plans adequate time to make the changes and communicate them to beneficiaries before the plan year in which the changes will go into effect.

H. Review of Medical Necessity Decisions by a Physician or Other Health Care Professional with Expertise in the Field of Medicine Appropriate to the Requested Service and Technical Correction to Effectuation Requirements for Standard Payment Reconsiderations (§§ 422.566, 422.590, and 422.629)

UHG supports the proposed change to § 422.566(d) and § 422.629(k)(3) linking the experience of the reviewing professional to the requested service on initial medical necessity reviews where there is a denial or a partial denial. UHG is dedicated to enhancing overall decision-making and the quality of reviews conducted by plans. We agree with CMS's acknowledgment that the reviewing professional does not, in all cases, need to be the same specialty or subspecialty as the treating provider due to resource limitations in specialized areas of medicine. We note that in some cases, reviewing professionals may have even greater expertise than the ordering physicians (e.g., internal medicine doctor vs. family nurse practitioner). Allowing flexibility in the specialty of the reviewer enables MA plans to route cases to an appropriate reviewer more quickly and streamlines reviews and clinical decisioning.

N. Clarify Language Related to Submission of a Valid Application (§422.502 and § 423.503)

CMS proposes to codify its authority to decline to consider a substantially incomplete application for a new or expanded Part C or D contract. CMS further proposes to codify the definition of a substantially incomplete application as one that does not include responsive materials to one or more sections of the MA or Part D application in the form and manner published annually by CMS. One example CMS provided of an incomplete MA application is "Failure to upload either a state license or documentation of a state licensure application before the CMS application due date."

UHC recommends that CMS issue specific guidance to clarify what constitutes an acceptable form of "documentation of a state licensure application" to be provided to CMS in the event a state license has been applied for, but not yet obtained, before the CMS application due date.

O. Updating Translation Standards for Required Materials and Content (§§ 422.2267 and 423.2267)

Standing Request for Translated Materials and Materials in Accessible Formats Using Auxiliary Aids and Services

CMS proposes to require that MA and Part D plans provide materials to beneficiaries in non-English languages and/or in an accessible format using auxiliary aids and services "on a standing basis" as long as a beneficiary remains enrolled in the plan or until the beneficiary requests that the plan provide required materials in a different manner. UHG notes that when beneficiaries request that a particular communication be provided in an alternative language or format, it does not necessarily mean that a beneficiary desires all communications in that language or format. Accordingly, UHG suggests CMS revise this requirement to allow the beneficiary the option to request a one-time alternate language or format communication or to request ongoing communications in the desired alternate language or format.

UHG also requests flexibility in the way MA plans can meet the beneficiary's request for an alternate format or language. For example, in time sensitive communications a fulfillment in Braille for a visually impaired beneficiary would take longer than a direct call or a conversation with an advocate. Finally, UHG requests CMS delay implementation of this proposal to at least the 2025 plan year to allow MA plans sufficient time to implement the requirement for all impacted communications. While a particular beneficiary may not receive a large variety of communications, ensuring availability of all plan communications in a variety of languages and formats will be a substantial undertaking.

Require FIDE SNPs, HIDE SNPs, and Applicable Integrated Plans to Translate Materials into the Medicare Translation Standard Plus Additional Medicaid Languages

UHG opposes CMS's proposal to require FIDE SNPs, HIDE SNPs, and applicable integrated plans (AIPs) to translate all required Medicare materials into any languages required by the Medicaid translation standard specified through their capitated Medicaid managed care contract in addition to the language(s) required by the Medicare translation standard at § 422.2267(a)(2). The number of languages an MA plan would need to account for in its communications is unsustainable, and the languages selected at the state level often do not meet the five percent threshold that is incorporated into the Medicare translation standard. Accordingly, UHG requests that CMS specify that the five percent threshold applies at the state level as well.

Alternatively, UHG requests that CMS specify that translation into state-required alternate languages apply to annual required communications only. This would ensure beneficiaries receive their benefit information in their selected language while retaining the option to request translated transactional communications as needed. CMS could permit the states to specify in the State Medicaid Agency Contract (SMAC) the documents the state requires to have translated into specific languages.

If CMS finalizes the translation requirement as proposed, UHG requests that CMS or the relevant state provide the translated templates for any required communications and CMS provide flexibility to meet the enrollee's needs using methods other than documents sent via US Mail. UHG estimates that industry cost to implement the requirements as proposed would significantly exceed the combined $12.5 million estimate CMS has noted. While the annual required materials could be plan-specific and the financial impact could be somewhat limited, the transactional communications are not plan-specific, so all of them would have to be translated to meet the proposed requirement. There will also be significant ongoing cost to maintain translated communications after the initial implementation.

P. Medicare Advantage and Part D Marketing (Subpart V of Parts 422 and 423)

Requirement for Multi-Carrier TPMO Materials Submission

CMS proposes requiring TPMOs to submit to CMS any material that the TPMO develops for multiple MA plans and Part D sponsors that meets the definition of marketing and that TPMOs receive prior approval, from each MA plan or Part D sponsor, of the material being submitted on their behalf. UHG recommends CMS maintain the current system that allows TPMOs to file materials in the Health Plan Management System (HPMS) and have MA plans decide whether to approve them through HPMS by opting-in or out when the materials are filed. The increased administrative work effort and resources to get approval of materials from MA plans outside of the HPMS portal seems counterproductive to increased program efficiency and could substantially delay getting necessary information to beneficiaries in a timely manner to make their plan selections.

Reducing TPMO Recording Scope

CMS proposes limiting the scope of calls that must be recorded by TPMOs to only those calls regarding sales, marketing, and enrollment instead of the current requirement to record all calls. UHG supports the proposed narrowing of the required TPMO call recording scope, and we recommend this change be effective immediately upon final publication of the final rule. UHG additionally requests that, upon implementation of the recording scope reduction, TPMOs not be required to retain previously recorded calls that fall outside the scope of marketing, sales, and enrollment.

TPMO Disclaimer

UHG believes CMS should revise the proposed TPMO disclaimer to more accurately reflect the role of a TPMO. The language in the proposed regulation and the disclaimer refers to TPMOs that "sell" for MA plans/Part D sponsors and "offer" plans. In practice, TPMOs do not offer plans and those

conducting only lead generation may not even distribute or sell plans. To capture the scope of TPMO types and activities more accurately, UHG suggests using broader terminology, changing "we do not offer every plan available" to "we do not represent every plan available." Further, UHG similarly suggests revising references to "sells" in 422.2267(41)(i) and 423.2267(41)(i), as not all TPMOs engage in the activity of selling.

UHG also has concerns with CMS's proposal to modify the TPMO disclaimer to require all TPMOs to list the names of the MA plans or Part D sponsors with which they contract in the applicable service area. Requiring TPMOs to list all represented plans may result in lengthy lists that may overwhelm and confuse beneficiaries. Additionally, given the nature of general advertising in the market (e.g., broad national/multi-service area ads), it is not feasible to list only those plans that are offered to all beneficiaries in the viewing area. UHG therefore recommends CMS either exclude the disclaimer on national and multi-service area ads or modify it to state that "Any information we provide is limited to those plans we represent in your area, which may include (listing)." Alternatively, UHG asks CMS allow MA plans to provide beneficiaries a link on digital and printed marketing and communication materials to a listing of all MA plans in their service area, as providing each MA plan name on written materials may not be feasible with material space/character constraints.

To the extent it is important to ensure further transparency regarding the scope of plans available, UHG recommends CMS consider requiring TPMOs make a disclaimer verbally during a TPMO's telephone call with a beneficiary. For example, CMS could require that TPMOs disclose the plans they represent in the consumer's service area at the beginning of any marketing or lead generation call with a beneficiary. That said, knowing the beneficiary's service area to read the appropriate disclaimer with all the names of the MA plans in the beneficiary's service area may not be achievable within the first 60 seconds of the call, so additional time and flexibility may be needed.

Prohibiting TPMOs from Distributing Personal Beneficiary Data to Other TPMOs

CMS proposes prohibiting a TPMO from distributing personal beneficiary data collected by that TPMO to another TPMO. UHG agrees that the practice of TPMOs selling or otherwise distributing a lead to multiple other TPMOs may result in unwanted outreach from multiple entities/individuals resulting in beneficiary confusion and abrasion. However, UHG believes that lead generation and distribution, if done in a controlled and exclusive way, is in the best interests of beneficiaries by giving them access to information about all the plans available to them. The proposed language would have the effect of eliminating arrangements between entities that generate leads only and entities that sell MA/Part D plans (i.e., licensed agents/agencies), as a TPMO is defined to include both lead generation entities as well as licensed insurance agents/agencies. To address CMS's concerns but maintain some flexibility for plans, UHG proposes the below changes to CMS's proposed language:

> "Personal beneficiary data obtained by a TPMO may only be distributed to, or used by, a TPMO and its representatives (e.g., a licensed insurance agency and its licensed agents representing the agency) as set forth below. In each instance where a TPMO obtains a beneficiary's data, the beneficiary's data may be shared with only one other TPMO (and its representatives) or an MA plan/Part D sponsor (properly covered by the consent to contact). If a TPMO obtains a beneficiary's data and uses it to contact that beneficiary, that beneficiary's data may not be distributed to other TPMOs or an MA plan/Part D sponsor. If a

TPMO distributes a beneficiary's data to another TPMO, it may not later use it to contact that beneficiary. For the purposes of the restrictions outlined in this section, an enrollment submitted to an MA plan or Part D sponsor by a TPMO does not constitute an instance of sharing of personal beneficiary data."

General Communications Materials and Activity Requirements

CMS proposes to further restrict the use of superlatives by prohibiting them unless sources of documentation or data supportive of the superlative are also referenced in the material. UHG supports CMS's requirement to the extent it is only requiring plans to provide citations to the substantiating supporting data as it would not be feasible to include the sources themselves in all marketing materials.

In addition, CMS proposes to require that the documentation or data supportive of the superlative reflect data, reports, studies or other documentation that has been published in either the current or prior contract year. UHG is concerned that a recent publication date is not necessarily reflective of recently sourced data. For example, one could publish documentation in 2022 based on data from 2015. UHG also notes that plans frequently utilize internal data that is not always publicly published. Accordingly, UHG recommends replacing "documentation that has been published" with either "documentation that is applicable to either the current contract year or prior contract year" or "documentation that is based on either the current contract year or prior contract year."

CMS also proposes placing limits around the use of the Medicare name, logo, and Medicare card to reduce concerns about misleading marketing activities and documents. UHG supports the clarifying restrictions on the use of the Medicare name, Medicare card or other Federal Government issued information to prevent uses that are likely to mislead a consumer into believing that they are interacting with a government entity or receiving an official government communication. The examples that CMS provides in the commentary to the proposed rule make clear various ways that the use of the Medicare name and government imagery (such as official looking seals, flags, eagles and government buildings) may be misleading to beneficiaries. Another example of misleading use may be the use of the Medicare name in a URL without other private branding or description. Conversely, we understand that it would be permissible to use the Medicare name and/or card images in a manner that accurately conveys to the consumer the nature of Medicare products that are being offered (for example, using Medicare and/or Medicaid card imagery in a material to convey the context that the plan is offered to Medicare and Medicaid-eligible beneficiaries as long as it is clear through prominent use of commercial branding and other language that the entity providing the products is a private commercial entity, such an MA plan or Part D plan sponsor).

Advertising Benefits in a Service Area Where those Benefits are not Available

CMS proposes adding a new restriction which prohibits MA plans from advertising benefits not available in a service area, unless doing so is unavoidable in a local market. UHG requests further clarification on the definition of "unavoidable" in this context and recommends CMS provide examples in the Medicare Communications and Marketing Guidelines (MCMG) or in a HPMS memo if no MCMG updates are planned for 2024. For example, we would consider national advertising, where the scale of the communication is broad and delivered through channels that cannot be

locally tailored as "unavoidably" advertising benefits that may not be available in a particular local market. This includes both television and digital communications, including display advertising.

CMS should also allow for flexibility in national advertising to the extent the benefits promoted are available to most beneficiaries in most service areas. Given the variation in plan benefits at a local level, a general representation of the average benefits or benefits available to the majority should be allowed in national or regional advertising and would ensure that the benefits promoted would be available to most of the Medicare eligible audience within the plan footprint. UHG proposes modifications to this requirement to read: "benefits that are not available to beneficiaries in most of the MA plan's service areas where the marketing appears, unless unavoidable..."

Beneficiary Contact Information

Generally, UHG supports efforts to protect beneficiaries from inappropriate sales pressures. However, we are concerned that CMS's proposals regarding limits on collecting beneficiary contact information at educational events and requiring a 48-hour delay between form collection and a personal marketing appointment, will inhibit beneficiaries' timely access to agent resources as well as their ability to enroll when election or coverage deadlines are nearing.

Beneficiary Opt-Out

CMS proposes a new requirement for each MA plan and Part D sponsor that reaches out to beneficiaries regarding plan business, to provide notice to all beneficiaries whom the plan contacts at least once annually, in writing, of the individual's ability to opt out of future calls regarding plan business. This would apply regardless of the plan's intent to contact the beneficiary again. Currently, plans are only required to provide this notice once, and not annually. UHG requests CMS confirm that the scope of activity impacted by this proposed revision is calls for "plan business" as described in the regulation (i.e., calls to discuss other products/services offered by the MA plan or Part D sponsor). It should not impact informational calls from the plan with information regarding the beneficiary's current plan.

Prohibiting Acceptance or Collection of SOA Cards or Beneficiary Contact Information at Educational Events

CMS proposes reinstating the prohibition on accepting Scope of Appointment forms (SOAs) and Business Reply Cards (BRCs) at educational events. UHG recommends that CMS not implement a complete restriction, as it may result in a significant reduction in educational events, potentially reducing health literacy and beneficiary access to information. UHG recommends CMS consider mitigating concerns regarding beneficiary pressure via less restrictive means. For example, by prohibiting the distribution of SOA/BRCs during the educational event but allowing access after the educational event concludes and requiring that the agent read a standardized statement or script that announces the availability of the SOA/BRCs while clearly noting that beneficiaries have no obligation to provide information.

Prohibiting Marketing Events from Taking Place within 12 Hours of an Educational Event in the Same Location

CMS proposes prohibiting marketing events from taking place within 12 hours of an educational event in the same location, defined as the entire building or adjacent buildings. UHG recommends that CMS consider clarifying that the prohibition on sales and marketing events within 12 hours of one another in the same location applies to a single agent conducting multiple events in the same location. In other words, it should not prohibit an agent from hosting a sales event in a location where another agent had held an educational event within 12 hours. Agents will largely be unable to determine when other agents have scheduled events. UHG also recommends that CMS consider reducing the proposed wait time between events to a one hour minimum. A reduced wait time of an hour still relieves beneficiaries of pressures to remain for the sales event, but also allows the convenience of educational and sales event occurring at the same location during the same day.

Prohibiting Personal Marketing Appointments from Taking Place until 48 hours after SOA Completion

CMS proposes codifying previous marketing guidance by prohibiting personal marketing appointments from taking place until 48 hours have passed after the SOA was completed by the beneficiary. UHG opposes this approach, as the 48-hour requirement without any exceptions may jeopardize a beneficiary's timely access to agent resources as well as their ability to enroll when election/coverage deadlines are nearing. Such delays will eliminate a beneficiary's ability to engage with an agent on a schedule that best fits their needs, even when the beneficiary initiates the discussion with inbound calls and walk-in appointments.

Beneficiaries that have transportation challenges or may have engaged friends or family members to accompany them may also be burdened with a need to leave and reschedule transportation and personal assistance. Engaging additional people in the process is common; for example, in Special Needs Plans (SNPs) 85 percent of beneficiaries have responsible parties gather the information on plan options and ultimately make the plan selection on behalf of the beneficiary. Unlike other MA plans, most SNP beneficiaries have this built-in added layer of protection from any alleged undue pressure and MA plans should be able to meet with the beneficiary's responsible party to the extent the responsible party can meet shortly after submission of the contact forms.

A 48-hour SOA wait may also be difficult for beneficiaries that choose to meet with multiple agents before making an enrollment decision. The current proposal will also significantly alter the operating structure of call centers that do not primarily operate on a pre-scheduled appointment basis.

The potential for beneficiary barriers to information and access is compounded when considering the combined effect of the SOA/BRC collection prohibition, 48-hours SOA waiting period, and 12-hour educational/marketing event delay. For example, a beneficiary who attends an educational event will not only have to separately contact the agent to set up an appointment rather than doing so at the event, but they must then also wait 48 hours from the time that appointment is set up until they can meet with an agent.

For these reasons, UHG recommends CMS not finalize the proposal to require an SOA 48 hours prior to personal marketing appointments. If CMS believes a 48-hour waiting period is essential, we recommend that CMS require an SOA 48 hours prior to personal marketing appointments "when practicable," and note the circumstances where such an exception to the 48-hour delay would be permissible, consistent with previous iterations of the CMS Medicare Marketing Guidelines.

Recommended exceptions to the 48-hour SOA delay include: beneficiary-initiated inbound calls, walk-in appointments, and proximity to election period deadlines (e.g., close of the Annual Enrollment Period (AEP)).

Establishing a 6-month Scope of Appointment (SOA) Expiration Date, unless Beneficiary has Renewed

CMS proposes modifying current regulations to limit the validity of SOAs and BRCs to six months. UHG recommends setting the auto-expiration date of SOAs and BRCs at nine months to ensure that permission to contact does not expire before the beneficiary's election period ends. Beneficiaries often engage with agents in advance of their election period eligibility. For example, a beneficiary on Original Medicare may engage an agent in January, but not qualify for an enrollment period until the AEP. A nine-month SOA/BRC expiration date would allow the agent to outreach and engage with the beneficiary during the AEP.

UHG also requests an exception to the expiration date for 5-star SNP plans, as these plans permit an individual to change plans throughout the year. As an example, this flexibility would be valuable for ISNP plan beneficiaries in a medical situation that changes suddenly. If a beneficiary is moved to an Assisted Living or Nursing Home setting as the result of a life changing experience, they can more easily shop for a new plan.

UHG also notes that the language of (c)(3)(iii)(A) as proposed is confusing as it includes SOAs, BRCs and requests to receive additional information, but only the SOAs document the scope of conversation. UHG recommends separating the limitations related to SOAs and those related to BRCs and requests to receive additional information. We suggest language under (c)(3), which is specific to personal marketing appointments, addressing the limits related to Scope of Appointment. Specifically, we recommend (c)(3)(iii)(A) to read as follows:

> "Market any health care related product during a marketing appointment beyond the scope agreed upon by the beneficiary and documented by the plan in a Scope of Appointment, which is valid the earlier of when the appointment is held or nine months following the date of beneficiary's signature date."

Separately, regarding § 422.2264(a) and § 423.2264(a), which address unsolicited contact and circumstances where contact is permissible, we propose adding a new (a)(4) as follows:

> "Consent to contact a beneficiary documented in a business reply card or request to receive additional information, excepting contact covered by and addressed in paragraph (c)(3) of this section, expires and is no longer valid nine months following the receipt of the consent to contact."

Requiring Plans to Establish Oversight Plan Monitoring Agent and Broker Activities

UHG recommends that CMS incorporate 'agent/broker' non-compliance reporting requirements into sub-regulatory guidance and provide plans with an opportunity to discuss reporting details with CMS Account Managers (timing, content, frequency, etc.). This discussion opportunity will allow for a cooperative reporting design that both meets CMS objectives and plan capability.

R. Part D Medication Therapy Management (MTM) Program (§ 423.153(d))

UHG supports efforts to increase access and eligibility for beneficiaries who suffer from chronic diseases and reducing variability of MTM eligibility criteria across plans.

Multiple Chronic Diseases

While UHG is generally supportive of CMS's proposal to codify the core chronic disease conditions so that there is alignment across all plans in MTM eligibility, UHG encourages CMS to revise the list of core chronic diseases and limit it to only those diseases that a pharmacist without specialized training could provide the most benefit to a beneficiary when completing a comprehensive medication review (CMR) and optimize the beneficiary's drug therapy.

UHG recommends that CMS consider removing several of the current core chronic diseases because they (a) require pharmacists with specialized training and experience to optimize outcomes; (b) require additional lab work or data points that are not easily accessible to the plan MTM pharmacist (in a call center or retail pharmacy) to either make strong clinical recommendations or assess if current therapy is safe and appropriately dosage adjusted for the beneficiary; and (c) may not directly provide benefit to a beneficiary and would be better handled via care/disease management programs involving interdisciplinary teams.

Specifically, UHG recommends CMS remove the following conditions from the core chronic disease list because the MTM pharmacists are not in the best position to positively impact a beneficiary's care with a CMR and routine targeted medication review assessments:

- **Mental health (including other chronic/disabling mental health conditions).** Generally, only pharmacists with specialized training and expertise in this chronic disease category can influence and/or improve beneficiary outcomes. Without specialized training such as board certification or residency training in mental health, an MTM pharmacist may not be equipped to provide the specialized care that is needed for these beneficiaries. In addition, when working with enrollees who have a mental health disease or condition, having an ancillary pharmacist who has not previously worked with an enrollee, make recommendations on drug therapy without knowing the enrollee's medical and drug history may cause disruption in the enrollee's treatment/therapy–which is already a complex condition to address and one that frequently involves input from other treating providers, such as a physician, a therapist and/or a counselor.
- **End-stage renal disease (ESRD).** A plan's MTM pharmacists (in call centers and retail pharmacy settings) may not have all the necessary data points, such as lab values, to make meaningful clinical recommendations around current therapy, gaps in care and/or any potential adjustments to therapy. Without lab values like BUN, Serum Creatinine, magnesium, potassium, calcium, and hematocrit/hemoglobin levels for example, the value the MTM pharmacist provides in a drug review may be less impactful. In addition, patients with ESRD are usually managed by interdisciplinary teams including a pharmacist who would be in the best position to make clinical recommendations (outside of MTM program) as part of the standard care that the ESRD beneficiary receives. The medication review done by the enrollee's care team is likely not captured as part of this MTM program and

CMS would not see that data; since these enrollees are likely already getting their medications reviewed by their care team, it may be confusing and duplicative to complete another CMR as part of this MTM program.

- **Alzheimer's disease.** The plan's MTM pharmacist may not be able to complete an interactive CMR with the beneficiary due to declining cognitive impairment. UHG believes this type] of review should be done outside of the MTM program where the beneficiary would best be served by an interdisciplinary care team, including a pharmacist, who can make recommendations around appropriate prescribing and current drug therapy based on their ongoing monitoring and intervention of the beneficiary's condition. UHG believes beneficiaries with Alzheimer's are better served by the beneficiary's care team, especially if the beneficiary is living in a setting where they are not managing their own medications and there are caregivers and/or a health care team that is responsible for overseeing their medication therapy.

As discussed above, UHG believes that there are certain chronic diseases where the most effective mechanism for managing the disease is through an interdisciplinary care team because the needs of the beneficiary require specialized training and/or additional care coordination. Because the MTM services provided under the MTM program are not the most effective mechanism for managing these types of specialized, complex diseases, UHG does not support adding HIV/AIDS or cancer to the list of core chronic diseases. UHG does support CMS's proposal to codify dyslipidemia as a core disease to include both chronically high (hyperlipidemia) and low (hypolipidemia) lipid levels, as well as CMS's proposal to change to specify only chronic congestive heart failure as a core disease.

To address CMS's concerns over the decline in MTM eligibility, UHG recommends CMS consider only including the following diseases on the core chronic disease list with a minimum requirement that the beneficiary have at least three out of the nine core conditions:

1. Bone disease-arthritis:
    - Osteoporosis
    - Osteoarthritis
    - Rheumatoid arthritis
2. Chronic congestive heart failure (CHF)
3. Diabetes
4. Dyslipidemia
5. Hypertension
6. Respiratory Disease limited to the following:
    - Asthma
    - Chronic obstructive pulmonary disease (COPD)

UHG believes that developing an MTM policy that includes these chronic diseases will help ensure alignment in MTM eligibility across plans, that the appropriate beneficiaries are targeted for enrollment and have access to the MTM program, and that MTM services are provided where they have the most value and/or benefit to the beneficiaries.

UHG recommends that to the extent CMS codifies a chronic disease list that it provides greater specificity in the definitions for each disease. Specifically, UHG asks that CMS clarify how "other

chronic lung disorders" are defined under respiratory disease and how "chronic/disabling mental health conditions" are defined under mental health.

Multiple Part D Drugs

UHG supports CMS's proposal to require that plans rely on a standardized source for the purpose of identifying maintenance drugs, such as Medi-Span or First Databank (FDB) if plans have the discretion to determine which to use.

UHG does not support CMS's proposal to decrease the number of Part D drugs a plan may require for an enrollee to be eligible for MTM from eight to five. A typical enrollee with three or more chronic diseases takes between seven and ten medications. For this reason, while changing the number of targeted medications to five would result in the inclusion of more enrollees, it is not the targeted population of enrollees that the MTM program is designed to benefit. UHG recommends that CMS maintain the number of Part D drugs at eight to ensure that the focus of the MTM program continues to be on enrollees who have more complex drug regimens and who are at the most risk of medication therapy problems.

Annual Cost Threshold

CMS proposes revising the method for calculating the eligibility cost threshold to be commensurate with the average annual cost of five generic drugs. UHG supports CMS's proposal to codify a drug spend threshold, but as discussed above, UHC does not support decreasing the maximum number of Part D drugs from eight to five and recommends that if CMS codifies a drug spend threshold, that it set the average annual price to eight generic drugs.

Clarifications

UHG requests clarification that CMS will continue to allow plans to require that an enrollee have a minimum of three chronic conditions out of the total number of targeted core conditions to be eligible for MTM.

Effective Date

CMS is proposing several substantial changes to the MTM program which will take time for plans to properly implement. If CMS finalizes the changes as proposed, UHG recommends that CMS delay the change to on or after January 1, 2026, to allow plans an adequate amount of time to enhance their systems and software to support the criteria changes and the potential increase in volume of enrollees, to hire and onboard additional administrative support and clinical staff, onboard new vendors to support the CMR volumes, and to provide clinical training on new core conditions.

V. Limitation on PDP Contracts Held by Subsidiaries of the Same Parent (§ 423.272)

UHC appreciates CMS's intent to provide more meaningful competition and provide a level playing field for Part D plans. There are currently only three plan benefit packages in a region; however,

there may be multiple contracts that require operational considerations upon consolidation (e.g., service area expansion, financial settlements, etc.). If CMS finalizes guidance as proposed, UHG recommends providing more than two bid cycles as a transition period for plans to consolidate contracts between plans. Specifically, UHG recommends a minimum of three bid cycles to ensure proper implementation.

W. Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act (§§ 422.326(c), 423.360(c), (§401.305(a)(2))

In the proposed rule, CMS proposes to amend the standard for when an MA plan or Part D sponsor has "identified" an overpayment. *See* 87 Fed. Reg. 79,452, 79559-60 (Dec. 27, 2022); *see also id*. at 79,455-56; *id*. at 79,699; *id*. at 79,719. Specifically, CMS "propose[s] to remove the existing standard and adopt, by reference, the False Claims Act [FCA] definition of 'knowing' and 'knowingly.' Under the proposed rule, an MA plan or Part D sponsor has identified an overpayment if it has actual knowledge of the existence of the overpayment or *acts in reckless disregard or deliberate ignorance* of the overpayment." *Id*. at 79,559-60 (emphasis added). UHG respectfully submits that the Notice's proposal to adopt the FCA standard is contrary to the statute's plain language and drafting history and would also render unlawful the rule's separate definition of "overpayment." In addition, as a policy matter, it would cause numerous practical problems that would massively outweigh any potential benefits. Instead of CMS's proposal, UHG recommends that CMS follow the plain language of the statute and adopt the following actual knowledge standard: an MA plan or Part D sponsor has "identified" an overpayment once it has determined that the overpayment exists. This definition is consistent with the statute, is workable for MA plans, and comports with the recent decision of the U.S. Court of Appeals for the District of Columbia Circuit concerning the same subject.

The Patient Protection and Affordable Care Act (the "Act"), Pub. L. No. 111-148, 124 Stat. 119 (2010), imposed an obligation on all entities that receive payments from federal healthcare programs to report and return overpayments that such entities identify on their own. The Act defines "overpayment" as "any funds that a person receives or retains under [Medicare or Medicaid] to which the person, after applicable reconciliation, is not entitled." 42 U.S.C. § 1320a-7k(d)(4)(B). And it requires that any "overpayment . . . be reported and returned [within] 60 days after the date on which the overpayment was *identified*." *Id*. § 1320a-7k(d)(2) (emphasis added). The Act provides no definition of the term "identified," which triggers the 60-day clock.

In 2014, CMS promulgated a rule that MA plans were deemed to have "identified" an overpayment under the Act when "the MA organization has determined, or *should have determined through the exercise of reasonable diligence*, that the MA organization has received an overpayment." *See* Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 79 Fed. Reg. 29,844, 29,923 (May 23, 2014) (emphasis added). UHG brought suit under the Administrative Procedure Act, challenging CMS's newly promulgated definition of "identified." *See UnitedHealthcare Ins. Co. v. Azar*, 330 F. Supp. 3d 173, 182 (D.D.C. 2018), *rev'd in part on other grounds sub nom. UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867 (D.C. Cir. 2021). The D.C. District Court vacated this provision because CMS had adopted too strict a definition of "identified" and, "[n]ot being Congress, CMS has no legislative authority to apply more stringent standards to impose FCA consequences through regulation." *Id*. at 190-91. CMS did not appeal that aspect of the D.C. District Court's decision. CMS now proposes to

replace that vacated standard with the FCA standard, which extends beyond actual knowledge to include "reckless disregard or deliberate ignorance." That proposal is flawed for at least four reasons.

First, CMS's proposal is contrary to the plain text of the Act. The Act provides that the 60-day clock starts running on the date an overpayment "was identified." 42 U.S.C. § 1320a-7k(d)(2). The statutory phrase "was identified" unambiguously indicates actual knowledge, not reckless disregard or deliberate ignorance. *See Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984) (requiring "giv[ing] effect to the unambiguously expressed intent of Congress"). To "identify" is to "establish," "indicate," or "determine" the identity of something. *See, e.g.*, Identify, *New Oxford American Dictionary* (3d ed. 2010) ("to establish or indicate who or what (someone or something) is"); Identify, *Webster's II New Collegiate Dictionary* (3d ed. 2005) ("to establish the identity of" or "to determine" the classification of); *see also* Identify, *Merriam-Webster Dictionary* (2023), https://www.merriam-webster.com/dictionary/identify. No one would think, nor does any dictionary suggest, that something has been "identified" if it merely *should have been* established, proved, or determined. A witness has not "identified" a suspect just because she should have recognized him but recklessly did not. Similarly, an overpayment has not been "identified" until an MA plan has actually determined that it exists. The proposed definition flouts the plain, unambiguous meaning of the statutory text.

Second, even if the statutory text had any ambiguity, CMS's interpretation is unreasonable, because it adopts a standard Congress already considered and rejected. *See Chevron*, 467 U.S. at 844-45. The legislative history shows that Congress intended "identify" to require something *more* than mere recklessness or deliberate ignorance. The initial version of the statute introduced in the U.S. House of Representatives in 2009 included a provision that an overpayment had to be reported within 60 days after it was *known*. H.R. 3200, 111th Cong. § 1641 (as introduced by the House, July 14, 2009). It specified that the meaning of "known" would be the same as the FCA's knowledge standard, which includes recklessness and deliberate ignorance. *See* 31 U.S.C. § 3729(b)(1). If Congress wanted to adopt the FCA's knowledge standard, then it would have stopped right there. But Congress instead adopted the Senate version of the bill, which substituted "identified" for "known." Pub. L. No. 111-148, § 6402(a), 124 Stat. at 755 (enacting H.R. 3590, 111th Cong. (2010)).

The drafting history thus makes clear that Congress affirmatively chose to adopt a standard *different* from the FCA standard. And as the D.C. District Court has already held in striking down the Rule's prior "reasonable diligence" standard, Congress plainly did not wish for "identify" to embody a liability standard lower than the FCA's knowledge standard. *See* 330 F. Supp. 3d at 191. The only remaining option, consistent with the plain language, is that Congress instead intended the *more* demanding standard of actual knowledge. That legislative choice should be controlling. *INS v. Cardoza-Fonseca*, 480 U.S. 421, 442-43 (1987) ("Few principles of statutory construction are more compelling than the proposition that Congress does not intend *sub silentio* to enact statutory language that it has earlier discarded in favor of other language." (citation omitted)). In short, even if the term "identified" were ambiguous, the one meaning it *cannot* possibly have is the precise recklessness/deliberate indifference standard that Congress already considered and rejected. CMS's proposal would impermissibly nullify Congress's choice.

Indeed, in *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867 (D.C. Cir. 2021), the D.C. Circuit read the term "identified" in precisely this proper way. There, the court made clear—consistent with the Act's

plain language and legislative history—that it understood the term "identified" as an actual knowledge standard: "the Rule only requires insurers to refund amounts they know were overpayments, *i.e.*, payments they *are aware* lack support in a beneficiary's medical records. That limited scope does not impose a self-auditing mandate." *Id.* at 884 (emphasis added). As the court repeatedly phrased it, the rule applies only to diagnostic code errors that an MA plan "*discovers*." *Id.* at 870.[41] "Aware" and "discover" is language of actual knowledge. *See* Discover, *Merriam-Webster Dictionary* ("to obtain sight or knowledge of for the first time" or "to find out").

Third, that understanding of the meaning of "identified"—that the overpayment obligation applied only to the return of actually known overpayments, i.e., overpayments that an MA plan is "aware" of and has "discovered"—was the critical underpinning for the D.C. Circuit's opinion upholding CMS's Overpayment Rule against the challenge that it violated the Act's actuarial equivalence requirement. There, the challengers had argued that CMS's definition of "overpayment" violated the statutory requirement of "actuarial equivalence," because it deemed all unsupported codes from MA plans to be "overpayments," regardless of the rate of unsupported codes in CMS's own data, which is used to set the MA payment rates. 16 F.4th at 882-84. The D.C. Circuit reasoned that CMS's overpayment definition did not violate the actuarial equivalence requirement, however, because while that requirement may apply at the larger population level, it does not apply to individual codes that an MA plan *discovers* are incorrect. *Id.* at 870-71, 886-87.[42] As the court reasoned, CMS's stringent definition of "overpayment" was permissible because it applied only to the "limited scope" of payments that MA plans "*are aware* lack support." *Id.* at 884.

In opposing certiorari in the same case, the U.S. Solicitor General's office likewise repeatedly defended the Rule's definition of overpayment on the ground that it applied only to diagnoses which the insurer "discovers" or "determines" are unsupported.[43] And CMS also recently expressed the same view in a new RADV rule, stating "Nor does this rule change the longstanding obligation of an

---

[41] *See also, e.g.*, *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 877-78 (D.C. Cir. 2021), *cert. denied*, 142 S. Ct. 2851 (2022) ("[I]nsurers are required to refund payments based on *unsupported diagnoses that they themselves discover through the course of their business*." (emphasis added)); *id.* at 882-83 (referring to CMS "recouping overpayments pursuant to the [Overpayment] Rule for codes that a Medicare Advantage insurer reported to CMS *but later discovered* were unsupported by beneficiaries' medical records." (emphasis added)).

[42] The court made clear that it was not reaching the issue whether CMS's overpayment rule would violate actuarial equivalence if it were implemented at the population level, as in the RADV context. *See* 16 F.4th at 892-93 & n.1.

[43] *See also, e.g.*, *UnitedHealthcare Insurance Co., et al. v. Becerra*, U.S. Br. in Opp. at I (U.S. No. 21-1140) ("Consistent with longstanding Medicare rules, the Overpayment Rule provides that *when an insurer discovers* that a previously submitted diagnosis is not supported by the beneficiary's medical record, the associated payment is an 'overpayment' subject to the 60-day return requirement and other procedural measures." (emphasis added)); *id.* at 5 ("If upon conducting an internal review of submitted diagnosis codes, *the plan sponsor determines* that any . . . diagnosis codes that have been submitted do not meet risk adjustment submission requirements, the plan sponsor is responsible for deleting the submitted . . . diagnosis codes as soon as possible." (emphasis added; citation omitted)); *id.* at 24-25 ("Thus, petitioners have not demonstrated that requiring Medicare Advantage insurers to *also* account for overreporting, *when discovered*, will lead to improper underpayment." (emphasis added)); *id.* at 27-28 ("As explained above, CMS has long required that, if a submitted diagnosis *is discovered to be invalid*, insurers must return any resulting payment." (emphasis added; citation omitted)); *id.* at 30-31 ("As explained, CMS has long required that Medicare Advantage insurers return payments for diagnoses *that are discovered* to be unsupported by medical-record documentation." (emphasis added; citation omitted)); *id.* at 33 ("The Overpayment Rule is consistent with insurers' longstanding obligation to refund payments for *diagnoses discovered* to be unsupported by medical-record documentation." (emphasis added)).

insurer to refund payments to CMS *if it learns* that a diagnosis lacks support in the beneficiary's medical record."[44] The repeated characterized of "identified" as requiring actual knowledge—by the D.C. Circuit, the Office of the Solicitor General, and CMS itself—is no accident. Rather, it is the only standard that is workable in a system where there is a widely acknowledged known high rate of diagnostic coding errors by providers across the industry and no freestanding audit obligation imposed on MA plans. In that context, CMS's proposed extension of "identified" to include recklessness/deliberate ignorance would cut out the critical underpinning that led the D.C. Circuit to uphold the Rule in the first place.

Fourth, the proposed FCA standard would also be difficult to administer and follow as a practical matter. The purpose of the statutory term "identified" is to pinpoint the moment in time at which failure to return an overpayment triggers liability under the FCA. The penalties under the FCA, a fraud statute, are severe: treble damages, statutory penalties, and even potential exclusion from the Medicare program. Given the potential severity of the consequences of failing to return an overpayment on time—and the fact that those consequences flow from *inaction*, not from affirmative conduct—it is critical that MA plans be able to determine with certainty when the 60-day clock starts to run. A plan can have little doubt about when it *actually* identified an overpayment, but the point at which it *would* have identified an overpayment had it not exhibited reckless disregard or deliberate ignorance will be anything but clear. That ambiguity will have particularly stark impact in the MA program, where there is often uncertainty as to whether a plan has been overpaid, and thus would result in further uncertainly about when the 60-day clock begins. The proposed standard would unsettle MA plans longstanding business expectations, and threaten the long-term viability of the program. At a minimum, it would launch endless disputes about how far MA plans must go toward removing errors to avoid being deemed reckless in disregarding them.

Instead of adopting the FCA standard, UHG recommends that CMS adopt the actual knowledge standard dictated by the plain language of the statute: an MA plan or Part D sponsor has identified an overpayment when it has determined that an overpayment exists. "It is a basic tenet that regulations, in order to be valid, must be consistent with the *statute* under which they are promulgated." *Decker v. Nw. Envtl. Def. Ctr.*, 568 U.S. 597, 609 (2013) (emphasis added) (citation omitted). Here, the statute sets forth an *actual* knowledge standard, and CMS should abide by that standard instead of the FCA's recklessness/deliberate ignorance standard it is now proposing.

IV. Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies

U. Shortages of Formulary Drug Products During a Plan Year (§ 423.120)

UHG understands CMS's concerns over drug shortages and the potential disruption that it can have on Part D enrollees' current therapies. UHG recognizes the challenges enrollees face when they do not have access to their current medications and must switch to another drug. UHG agrees with

[44] *See* CMS, Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, at 25 (Jan. 30, 2023).

CMS that enrollees should have coverage for a therapeutically equivalent or interchangeable non-formulary alternatives but recommends that CMS continue to allow plans to have the flexibility to require enrollees meet the formulary exception requirements in certain circumstances.

CMS proposes that Part D plans permit enrollees to obtain coverage for a therapeutically equivalent drug or interchangeable biological product for the duration of the shortage without requiring those enrollees to satisfy formulary exception, prior authorization, or step therapy requirements, as applicable. UHG recommends that CMS allow plans the flexibility to require that enrollees request an exception if the alternative drug/medication is non-formulary (NF) or a prior authorization/step therapy (PA/ST) review if the alternative drug/medication has a utilization management (UM) requirement to ensure appropriate Part D utilization. With this flexibility, plans could verify that the drug continues to be in shortage and the PA team would be able to review and identify the most appropriate alternative course of treatment given an enrollee's specific medical condition. A drug that is in shortage may have multiple indications with different therapeutic alternatives depending on the enrollee's diagnosis. The plan may not always have the complete medical history or record for the enrollee. If a drug recall or shortage is extended to the class level, the selection of alternatives would become even more broad, making it exponentially more complex to manage to ensure continuity of care and adherence to CMS guidance of medically accepted indications. The exception or authorization would then be put in place until the end of the year. Allowing this flexibility would ensure that enrollees receive a review of their adjusted therapy and continuity of treatment throughout the plan year.

UHG has concerns with CMS's proposal to have plans allow pharmacies to utilize the Dispense as Written 8 (DAW8) code to specify that an equivalent brand product is being dispensed due to unavailability of any generic formulary products. Plans do not have the ability to know whether the DAW8 is being used by pharmacies beyond the duration of the generic drug's shortage and would not have any recourse or ability to audit the usage of DAW8 by pharmacies for fraud, waste and abuse.

AA. Part D Proposed Automatic Shipment Requirements (§ 423.505)

UHG supports ensuring consistent and reliable access to Part D drugs for enrollees and supports CMS's proposal to codify its current auto-ship policies. Specifically, UHG supports CMS's proposals for Part D plans to require their network pharmacies that offer auto-ship services to:

- Provide automatic shipments only to Part D enrollees that opt-in, on a drug-by-drug basis, after an initial fill.
- Provide a minimum of two shipping reminders prior to each shipment.
- Refund any cost sharing paid by the Part D enrollee and reverse the claim when the enrollee reports the shipment is not needed or wanted, reverse the claim, and delete the PDE.
- Discontinue auto-ship services when a Part D enrollee requests to opt-out or when notified that a Part D enrollee has entered a skilled nursing facility or elected hospice coverage.

UHG recommends that CMS consider allowing only one shipping reminder by a Part D plan's network pharmacies when an enrollee is receiving an automatic shipment of prescriptions that are for a 30-day supply. UHG believes one successful reminder to an enrollee is sufficient between 30-day supply shipments. UHG also encourages CMS to consider issuing model language for the

shipping reminders that Part D plans can share with their network pharmacies to ensure the notifications that enrollees receive are consistent.

Refund Policy

UHG recommends CMS not finalize the refund policy as proposed. UHG understands CMS's desire to ensure that enrollees are protected from potential cost, safety risks, and the inconvenience of unwanted or unneeded prescriptions being filled. However, given the required shipment reminders, unique enrollee circumstances, and the potential for fraud, waste, and abuse if the enrollee is not required to return the medication, UHG believes that the best way to ensure enrollees are protected from unneeded and/or unwanted shipments is at the network pharmacy level. UHC encourages CMS to allow plan network pharmacies the flexibility to create their own refund policies since they are in the best position to collaborate with the enrollee on the appropriateness and safety of the auto-ship services and to determine the circumstances under which an enrollee is entitled to a cost share refund.

Discontinuation

UHG supports CMS's proposal to require plans to discontinue auto-ship services if an enrollee requests to opt-out and when the network pharmacy receives notification that an enrollee has entered a skilled nursing facility (SNF) or elected hospice. UHG has concerns, though, with using information through data systems, such as the MARx system, to discontinue auto-ship services because it does not provide real-time data. If network pharmacies are required to discontinue auto-ship services based on data that is not real-time, there is potential for disruption of care delivery and coordination. For example, there may be a situation where a network pharmacy receives information through the data system that an enrollee has entered a SNF, but by the time it is received, the enrollee has already left the SNF and returned to accessing care through a community center. In this situation, if the network pharmacy were to discontinue the enrollee's auto-ship, the enrollee may experience a disruption in therapy. Since notification through a data system may not be timely, UHG recommends that CMS only require discontinuation of auto-ship services when notification is received from the enrollee or the enrollee's authorized representative that the enrollee has entered a SNF or elected hospice.

AC. Application of 2-Year Ban on Reentering the Part D Program Following Non-Renewal (§§ 423.507 and 423.508)

UHG understands CMS's intent in promoting stability at the Part D plan (PDP) region level. However, UHG has concerns that prohibiting plans from being able to offer a new PDP contract for two years in a region where the Part D sponsor terminated a contract limits the number of alternative PDP choices that are available to enrollees and decreases enrollees' access to benefits.

UHG supports exempting new Employer Group Waiver Plan PDPs from the two-year ban and encourages CMS to consider other exemptions, such as for any PDPs that are included as part of an acquisition by a Part D sponsor.

AD. Crosswalk Requirements for Prescription Drug Plans (§ 423.530)

Provisions included in the recently passed Inflation Reduction Act (IRA) are substantially changing the Part D program. As a result of IRA-related changes, plans will need to consider the impacts on their formulary design, benefits, and network strategy and what changes they may want to make in order to continue to provide attractive and innovative Part D plan offerings to beneficiaries. Due to the year-to-year variability that will likely occur as a result of the IRA changes going into effect over the next several years, UHG recommends that CMS continue to provide plans with flexibility to make changes and that it not implement its proposed restrictions on existing PDP crosswalk practices. Maintaining the existing crosswalk practices will allow plans to provide beneficiaries with sustainable and affordable plans. UHG also recommends that CMS consider the impact that the IRA-related changes may have on plan premiums and national averages from one year to the next and that it not rely solely on a "current versus projected" comparison of premiums as a criteria for cross walking.

If CMS finalizes its proposed crosswalk changes, UHG strongly recommends that CMS delay the implementation of these requirements until after Calendar Year 2026 to allow plans the ability to assess and amend any required benefit changes.

AH. Gross Covered Prescription Drug Costs (§423.308)

At §423.308, CMS previously defined the term "gross covered prescription drug costs" (GCPDC) to include those costs "actually paid" by the plan, or as CMS further clarified, "costs actually incurred by the plan that are net of direct and indirect remuneration (DIR), including discounts, rebates, or other price concessions typically received and applied after the point of sale." At the time this regulatory definition was finalized, it was specifically related to the calculation of Part D reinsurance amounts. In this proposed rule, CMS notes that the concept of GCPDC is now relevant in another context – IRA changes made to the Social Security Act. Given this new context, CMS proposes to amend the definition of GCPDC by removing the phrase "actually paid." Removing this term "clarifies that GCPDC are not net of all [DIR]." CMS further elaborates that this change will not impact the calculation of Part D reinsurance amounts.

UHG strongly disagrees with this proposed change and recommends the agency not include it in the final rule. While we appreciate the analysis CMS provides on why this change would not impact the calculation of reinsurance payments, the proposed rule fails to provide even a cursory regulatory impact analysis of how this change might impact other dynamics of the Part D program, or implementation of the new drug negotiation program for which CMS says the change is needed. Stakeholders cannot adequately provide feedback on proposed changes if agencies do not outline their rationale and intent in making them or provide an evaluation of the quantitative and qualitative benefits and costs. In this instance, CMS has alluded to the idea that removing the phrase "actually paid" from the definition of GCPDP will impact the implementation of the IRA's drug negotiation provisions, but CMS has not described what policy goal this change is meant to achieve.

As we describe below, we believe this change could have far reaching consequences for the relationship between plans and manufacturers in their negotiations outside of new provisions added by the IRA. If UHG is correct and CMS implements the proposed change it will have violated the Administrative Procedure Act by not adequately apprising "interested parties of the issues to be

addressed in the proposed rule with sufficient clarity and specificity to allow them to participate in the rulemaking in a meaningful and informed manner."[45]

Given the clarification that the removal of "actually paid" means GCPDC are not net of all DIR, we are left to deduce that CMS's intent may be to create its list of drugs eligible for negotiation under the IRA based on gross spending. UHG would strongly disagree with this approach for the reasons below but would need additional information from CMS in order to provide more thorough feedback.[46]

The intent of the IRA's drug negotiation program was for Medicare to negotiate a select number of drugs that had been on the market for a significant amount of time and lacked competition. Implicit in the concept of competition in the prescription drug market is whether pharmacy benefit managers (PBMs) can negotiate rebates off gross price from pharmaceutical manufacturers on behalf of Part D plan clients. If CMS selects drugs based on gross spending, rather than net, it could capture products for which PBMs already negotiate significant savings – even if those products lack generic or biosimilar competition.

Based on an OptumRx analysis of the CMS Part D Dashboard and estimated national rebates based on OptumRx's understanding of the market, we created an illustrative model to show how drug selection changes if the list of negotiation-eligible products is made based on gross or net prices. When using gross prices, five products are selected whose net prices today are lower than the statutory ceiling prices established by the IRA (compared to three when using net prices). This dynamic represents an additional $800 million in savings in the first year alone that CMS could generate by constructing the list of negotiation-eligible products based on net prices (assuming that every product's negotiated price is the statutory maximum). Constructing the list based on gross prices would make it very difficult for CMS to negotiate a Maximum Fair Price that is lower than the net price PBMs already have. In this way, the IRA's drug negotiation program would simply replace PBMs' private market competition with government negotiation – but without correcting the market failure the IRA was envisioned to address.

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System

UHG supports efforts to ensure all people receive equitable, high quality and value-based care and believes progress can be made on those goals through the Star Ratings Program. However, the Quality Rating System proposals, in aggregate, would ultimately have a negative impact on beneficiaries' access to care and benefits, and may unravel and delay advances in health equity such as transportation benefits or utilities support for those with SDOH barriers. UHG believes its recommendations will help CMS more effectively improve quality and advance health equity by

[45] *Am.Md. Ass'n v. United States,* 887 F.2d 760, 767 (7th Circ. 1989).

[46] In addition to implications around how the IRA's drug negotiation program would be implemented, this change could also impact other parts of the Part D program not discussed in the proposed rule and result in CMS violating the Non-Interference Clause and conflicting with Congress' ratification of the definition of GCPDC when it enacted the IRA.

preventing the unraveling of recent and proposed advancements in health equity, continuing integration and alignment of quality into the care journey, accelerating innovation in care and beneficiary benefits and mitigating changes that may adversely affect beneficiary safety. UHG highlights five of its recommendations below:

- UHG opposes CMS's proposed changes to the Improvement Hold Harmless Provision.
- UHG supports the addition of the Health Equity Index (HEI) but recommends CMS phase in the replacement of the Reward Factor with the HEI, keeping both the reward factor and HEI until the 2029 Star Ratings, to allow time for the HEI to be further refined and improved.
- UHG supports the expansion of the age range for the Part C Star Rating colorectal cancer screening measure to include 45- to 49-year-old beneficiaries.
- UHG does not support risk-adjusting the Part D medication adherence measures for sociodemographic status (SDS).
- UHG also does not support the addition of Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults (POLY-ACH), Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults (POLY-CNS) and Concurrent Use of Opioids and Benzodiazepines (COB) measures to the Star Ratings as currently defined.

D. Adding, Updating, and Removing Measures (§§ 422.164 and 423.184)

Kidney Disease Monitoring

UHG supports the removal of Diabetes Care – Kidney Disease Monitoring and Medication Reconciliation Post-Discharge and the additions of Care for Older Adults – Functional Status Assessment and Kidney Health Evaluation for Patients with Diabetes, which aligns with the National Kidney Foundation recommendations.

We request clarification from CMS that it will include both the stand-alone Medication Reconciliation Post-Discharge and the composite Transitions of Care measure (which includes the Medication Reconciliation Post-Discharge measure) in the 2024 and 2025 Star Ratings program.

Colorectal Cancer Screening

UHG supports the expansion of the age range for Colorectal Cancer Screening to include 45- to 49-year-old beneficiaries. We recognize the importance of promoting these screenings for this age group and believe MA plans should cover them in alignment with recommendations set forth by the U.S. Preventive Services Task Force (USPSTF) and subsequently adopted by NCQA. The USPSTF recommended screening adults ages 45 and older who had no signs or symptoms of colorectal cancer and were at average risk for colorectal cancer. Beyond colonoscopy, certain colorectal cancer screening tests were part of that recommendation. At the time of the age range adjustment, the CMS NCD 210.3 Colorectal Cancer Screening Tests did not yet reflect this adjustment, causing confusion for providers regarding what would or would not be covered. In the future, we propose that CMS adjust or publish traditional CMS coverage criteria consistent with the timing for applying new or updated quality standards to MA plans.

Part D Measures – Polypharmacy and Concurrent Use of Opioids and Benzodiazepines

UHG does not support the proposed additions of Concurrent Use of Opioids and Benzodiazepines (COB), Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH), and Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults (Poly-CNS) in their current forms because they do not distinguish between inappropriate and appropriate polypharmacy. The premise of these measures appears to be that concurrent overlapping therapy for 30 or more days of two or more anticholinergic medications, three or more CNS medications, or the combination of opioids and benzodiazepines is always inappropriate. However, for measures to be truly effective and not cause undue harm to patients, CMS needs to make a distinction between inappropriate polypharmacy (the use of unnecessary or excessive medication) and appropriate polypharmacy with the clinical goal of managing multiple comorbid conditions in the same patient.[47]

The current definitions of these measures make no allowances for:

- Beneficiaries with clinical chronic conditions who require this combination of medications because they are medically necessary. For example, a beneficiary with schizophrenia will likely need to be on an antipsychotic (on the Poly-CNS and Poly-ACH drug list), a mood stabilizer like divalproex (on the Poly-CNS drug list) or an antidepressant (on the Poly-CNS and Poly-ACH list), and if they also have other comorbid conditions like overactive bladder they may need to be on an antimuscarinic (Poly-ACH drug), all of which may be clinically appropriate.
- Beneficiaries who have been clinically stable on combinations of medications long-term who cannot be appropriately deprescribed therapy within the 30-day overlap period that places beneficiaries in the numerator.
- Dosage reductions while not discontinuing medications completely.
- Prescriptions written and filled for at least 30 days even though the beneficiary may not necessarily be taking the medication or was asked to keep it on hand if needed.
- The fact that most of the medications listed within the drug lists for the Poly-ACH, Poly-CNS, and the COB measure have no good therapeutic alternatives and would result in indexing a beneficiary into the numerator for at least one of these measures (e.g., a Medicare beneficiary on a benzodiazepine for anxiety may get switched over to a SSRI which is also considered inappropriate for a 65 year old plus patient and is on the Poly-ACH and Poly-CNS drug list).
- Common medications used to treat behavioral health conditions such as anxiety, depression, or psychosis are listed on both the Poly-CNS and Poly-ACH medication list. The somewhat duplicative measures will place beneficiaries at risk of not having access to common behavioral health therapies that are medically indicated.

UHG agrees inappropriate polypharmacy is a clinical concern and must be addressed to keep Medicare beneficiaries safe. However, UHG predicts if the measures are implemented in their current state, they will lead to beneficiaries being at risk of not having access to medically appropriate therapies where therapeutic necessity is documented and monitored against each diagnosis. As such, UHG recommends CMS:

[47] Hughes, Carmel. "Appropriate and Inappropriate Polypharmacy—Choosing the Right Strategy." *British Journal of Clinical Pharmacology*, 9 Nov. 2020, 10.1111/bcp.14589. Accessed 4 Dec. 2020.

- Work with the Pharmacy Quality Alliance (PQA), the measure steward, to look for more effective ways of measuring inappropriate polypharmacy and make a distinction between appropriate and inappropriate use. UHG recommends that CMS and PQA consider having these measures apply only to the disease states where the highest risk of adverse events has been documented with this combination of therapies. For instance, there are known risks and limited benefits for enrollees with Alzheimer's Disease and dementia to being on three or more CNS active medications and a combination of opioids and benzodiazepines.[48] The National Institute of Aging (NIA) has developed a Deprescribing Research Network whose goal is use deprescribing to improve the quality of care in older adults. PQA could work with the NIA to understand what measures would be impactful to ensure the measures are not causing undue harm to beneficiaries.
- Extend the concurrent overlap days to at least 120 days (or more) to ensure that health plans and prescribers can work with beneficiaries and caregivers to come up with realistic plans around deprescribing, dosage reduction, and tapering therapy and that only beneficiaries who are on the concurrent medications long-term are included in the numerator of the measure.[49] [50] [51]
- Should CMS finalize inclusion of the poly-pharmacy measures, we recommend including only one of them in the Star Ratings program due to the overlap of the drug list across multiple measures as well to minimize potential undue harm.

Part D – Medication Adherence

Risk Adjustment for Sociodemographic Status

UHG does not support CMS's proposal to implement risk adjustment based on sociodemographic status (SDS) to the Part D medication adherence measures. There should be one set of medication adherence standards by which plans are measured; risk adjusting for SDS will effectively create multiple standards. Risk adjustment based on SDS also adds further complexity to an increasingly complex Star Ratings program without sufficient increased benefit to quality measurement. CMS even acknowledges this increased complexity. CMS says it intends to incorporate the SDS risk adjustment to the medication adherence measures reported by CMS to Part D sponsors only in the last monthly patient safety report for the measurement year because of the time commitment involved with implementing the SDS risk adjustment to the patient safety reports.

CMS should not finalize this proposal, or any of the changes to the pharmacy adherence measures, before making available additional information on the proposed methodology and allowing plans to provide comments, including: (1) whether it would be an enrollee-level adjustment to the Percent Days Covered calculation or a plan-rate adjustment at the measure level; (2) the calculated changes to the Categorical Adjustment Index (CAI); (3) updated patient safety-reports that incorporate each of the changes; and (4) relevant coefficients consistent with the information CMS provides for the CAHPS case-mix adjustment each year.

[48] The dangers of polypharmacy and the case for deprescribing in older adults | National Institute on Aging (nih.gov).
[49] Clinical Review: Recommendations for the Tapering of Benzodiazepines (uhcprovider.com).
[50] Going Off Antidepressants - Harvard Health Publishing - Harvard Health.
[51] A Method for Tapering Antipsychotic Treatment That May Minimize the Risk of Relapse - PMC (nih.gov).

Inpatient and Skilled Nursing Facility Adjustments

UHG does not support removing the existing adjustments for inpatient (IP) and skilled nursing facility (SNF) stays. CMS began the IP stays adjustment in 2011 and expanded that adjustment to SNF stays in 2013 to account for the time the Part D plan was not responsible for prescription drug coverage. Because skilled stays are covered under Part A, there would be no Part D claim, and without the adjustments the beneficiary would inaccurately be counted as non-adherent even if the beneficiary was adhering to the medication. CMS claims that the IP/SNF stay adjustment has a "very minimal" impact to the distribution of measure rates, but this does not consider the disparate impact on certain populations such as beneficiaries in ISNPs. Prior to finalizing this proposal, UHG requests CMS make available additional information supporting its claim that this will have minimal impact.

In addition to SDS risk adjustment and the proposed removal of the adjustment for IP and SNF stays, CMS also proposed a change from member-years adjustment to continuous enrollment for the medication adherence measures. CMS also contends that the above changes will be finalized independently of one another, but UHG disagrees with that position. In order to better evaluate their impact, CMS should provide plans with the information and data discussed above and provide additional time for plans to provide feedback on the proposed changes.

E. Measure Weights (§§ 422.166(e) and 423.186(e))

UHG supports reducing the Patient Experience/Complaints and Access measures weight to two beginning with the 2026 Star Ratings. UHG agrees with CMS that the weight reduction appropriately accounts for the value this measure category contributes to achieving high quality care and better aligns the total contribution of patient experience and outcome measures within the Star Ratings program.

UHG supports adding a question to the CAHPS survey related to whether enrollees' personal doctors dismiss symptoms that are important to them but does not support adding this as a measure to the display page, as it is a measurement of providers rather than plans.

F. Guardrails (§§ 422.166(a)(2)(i) and 423.186(a)(2)(i))

UHG supports the retirement of guardrails in the 2026 Star Ratings. However, during the transition to outlier removal in the 2024 Star Ratings, guardrails should be applied to the 2024 cut points from the actual 2023 cut points with mean resampling and not the adjusted outlier removal cut points. As stated by CMS, the outlier removal methodology is meant to stabilize cut points; however, applying the guardrails from adjusted outlier removal cut points can have undue and substantial movement while removing consistency year over year counter to the intention of creating stability. We propose that guardrails should be used to ease the transition to outlier removal cut points.

G. Health Equity Index Reward (§§ 422.166(f)(3) and 423.186(f)(3))

UHG supports the addition of the Health Equity Index Reward to the Star Ratings program but has several recommendations to further strengthen the calculation as well as reward MA plans for high

and improved performance for beneficiaries with social risk factors (SRFs) while minimizing unintended consequences of changing existing framework.

To strengthen the impact of the HEI goals, UHG recommends the following changes:

1. Include both the HEI and Reward Factor through SY29

UHG requests that CMS phase in the replacement of the Reward Factor with the HEI, keeping both the reward factor and HEI until the 2029 Star Ratings, to allow time for the HEI to be refined and improved. If the reward factor were removed and HEI were in place today, millions of beneficiaries could be negatively impacted since their plans would not qualify for HEI and likely have limited ability to provide tailored benefits (for example, transportation or utility benefits) for individuals with SRFs. A phased approach would give plans time to enroll beneficiaries with SRFs. This could be particularly challenging for plans in states that require or request that MA parent organizations have state specific contracts for DSNP products and the corresponding phase out of DSNP look-alike plans. It also allows for reporting of HEI scores and measure thresholds for a couple of years prior to implementation, giving baselines for goal setting and allowing for a more stable environment as the HEI Reward evolves and ideally aligns with other quality organizations such as NCQA on health equity strategies such as Health Equity Accreditation and Health Equity Accreditation Plus. Aligned goals, populations, and strategies would enable providers and plans to advance health equity at greater scale and more efficiently.

2. Add an improvement and/or disparity measurement to the HEI to effectively incentivize quality improvement for individuals with SRF and improve health equity.

The HEI looks within group differences, which is an important metric to consider when trying to improve quality for enrollees with SRFs. This effectively compares members with SRFs amongst themselves as opposed to incentivizing improvement of health outcomes of members with SRFs compared to members without SRFs or general improvement across measures. UHG wants to improve health outcomes of these members holistically and recommends the HEI incentivize overall improvement relative to members without SRFs and general improvement overall. The HEI as proposed does not explicitly reward plans for disparity reduction between enrollees with SRFs and enrollees without SRFs, nor does it reward improvement for enrollees with SRFs. These are especially important given the HEI looks at just two SRFs and does not consider intersecting and overlapping SRFs. Without the ability to capture improvement or disparity reduction, similar to the Medicare Health Equity Summary Score (HESS) from the CMS Office of Minority Health, plans servicing the most underserved populations may be disadvantaged. As such, UHG recommends that contract measures be scored on within-group scores, based on reduction of disparity between members with SRFs and without, and general improvement for members with SRF. The contract measure would receive the highest of the three to allow three paths toward a positive HEI.

We acknowledge this would alter the HEI scores from current modeling. However, CMS stated that in simulations on removing the Reward Factor and replacing it with the HEI, just seven contracts, or 1.7% gained one-half star on the overall rating and 54% of contracts lost one-half star. With these changes, the HEI could be a powerful replacement for the Reward Factor and incent plans for both

absolute performance on enrollees with SRFs, but also encourage plans for both disparity reduction and continuous improvement to improve quality scores for the most underserved enrollees.

3. Provide additional details around calculation

UHG appreciates the details CMS provided about the HEI, but the proposed rule did not provide all the requisite information to allow MA plans to perform a complete evaluation of the HEI and the expected impacts. Specifically, UHG requests CMS provide responses to the following questions:

- What are the expected measure level performance thresholds for each of the thirds at a measure level?
- Given CMS is combining multiple years of data, how does CMS intend to calculate and apply the trend for multiple years of data?
- How will measure reliability be calculated?
- If a contract does not meet the minimum share of enrollees with SRFs, will that contract's score be included in the measure level thirds calculation?

H. Improvement Measure Hold Harmless (§§ 422.166(g)(1) and 423.186(g)(1))

UHG recommends CMS not finalize the proposed change to the Improvement Hold Harmless provision. This change would have a disproportionately negative impact on the Star Ratings of plans with beneficiaries who have SRFs. Indeed, it would dwarf any positive impacts of the Health Equity Index reward and Categorical Adjustment Index combined, undoing much of the progress the Star Ratings system has made to appropriately incentivize quality health care for members with SRFs and advance health equity. For example, had it been implemented in the 2023 Star Ratings, the improvement measure hold harmless proposal would have prevented DSNPs across the industry serving 766,000 beneficiaries (17 percent of MA DSNP membership) from reaching four stars. If this change is made, MA plans may not be able to provide critical supplemental benefits designed specifically to address Social Determinants of Health such as food, over-the-counter medications, transportation and utility support.

The proposed change would also penalize contracts that provide high quality care and experience to their enrollees year over year. The improvement measure as it exists today includes situations in which it is mathematically impossible to achieve the statistically significant improvement level due to a contract's high performance on measures. For example, a perfect Call Center measure score two years in a row would result in an adverse measure improvement score ("no significant change"), penalizing high performance plans for perfect performance. It is true that a 4-star contract may have measures in which there is room for improvement, however, it may also have others at 5 stars. While there is an existing measure level hold harmless if the measure is at 5 stars each year, this is characterized by a 0 rather than a 1 in the technical calculation. The existing hold harmless provision for 4 stars plan allows these high performing contracts to be measured without artificially low improvement measures that are not measuring what they were intended to.

While we oppose CMS's proposed changes to the improvement measure hold harmless, we recommend the following changes to the extent CMS moves forward with them:

- If a measure receives 5 stars in two consecutive years, CMS should score them as statistically significant improvement to acknowledge ceilings on measure performance.
- Reduce the weighting of the Improvement Measures back to 3 or combine the Part C and Part D improvement measures into a single measure (similar to the duplicated measures Complaints about the Health/Drug Plan and Enrollees Choosing to Leave the Plan) to balance overall improvement incentives with general performance for a program that has driven quality improvements and innovative benefits to a diverse population and specifically those with social determinants of health (SDOH) and SRF challenges.
- Raise the Hold Harmless threshold, but only to 4.5 instead of 5.
- Phase in the change, raising the threshold to 4.5 for two years before increasing to 5.

TAB 14

As of: March 04, 2024
Received: February 13, 2023
Status: Posted
Posted: February 15, 2023
Category: Health Plan or Association
Tracking No. le3-a2ln-gxt7
Comments Due: February 13, 2023
Submission Type: API

PUBLIC SUBMISSION

Docket: CMS-2022-0191
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024

Comment On: CMS-2022-0191-0001
Medicare Program: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, etc.

Document: CMS-2022-0191-0658
Comment on CMS-2022-0191-0001

Submitter Information

Email: perezc6@cvshealth.com
Organization: CVS Health

General Comment

See attached file(s)

Attachments

CVSH 2024 MA and Part D Comment Letter 2.13.23 FINAL

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

Submitted electronically via www.regulations.gov

February 13, 2023

The Honorable Xavier Becerra
Secretary, Department of Health and Human Services

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services

U.S. Department of Health and Human Services
Attention: CMS-4201-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comments on Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program and Medicare Prescription Drug Benefit Program (CMS-4201-P)

Dear Secretary Becerra and Administrator Brooks-LaSure:

CVS Health appreciates the opportunity to respond to the Medicare Advantage (MA) program and Medicare Prescription Drug Benefit (Part D) proposed rule,[1] published in the Federal Register on December 27, 2022.

CVS Health serves millions of people through our local presence, digital channels, and our nearly 300,000 dedicated colleagues – including more than 40,000 physicians, pharmacists, nurses and nurse practitioners. Our unique health care model gives us an unparalleled perspective on how systems can be better designed to help consumers navigate the health care system – and their personal health care – by improving access, lowering costs, and being a trusted partner for every meaningful moment of health. And we do it all with heart, each and every day.

We appreciate CMS' efforts to enhance beneficiaries' experience with MA and Part D. For years, Medicare Advantage Organizations (MAOs) and Part D Plan Sponsors (PDPs) have been leading the way in combining population-level health management with person-centered care coordination, reduced cost-sharing, and supplemental benefits and innovative programs to address medical and social risk factors and gaps in care.

[1] CMS, Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications, 87 Fed. Reg. 79452 (Dec. 27, 2022).

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

MA, PDP and MA-PD plans have, and will continue to offer high-value options to the Medicare population by[2]:

- **Providing affordable coverage to beneficiaries**
  - 98% of MA beneficiaries have access to at least one $0 premium MA plan with prescription drug coverage[3]
  - On average, MA beneficiaries report spending $1,965 less in out-of-pocket costs than those in Traditional Medicare[4]
  - MA beneficiaries receive cost protections not available in Traditional Medicare such as a $7,550 maximum out-of-pocket limit in 2022[5]
  - Beneficiaries in MA-Part D plans have experienced 15% lower combined medical and prescription drug costs compared to Traditional Medicare beneficiaries[6]

- **Offering benefits that support person-centered care[7]**
  - 99.9% of MA plans offer at least one supplemental benefit at no extra cost to the beneficiary
  - Over 90% of MA plans offer vision, hearing, dental, or fitness/wellness benefits, with most plans now offering all four benefits

[2] Seshamani M., Fowler E., Brooks La-Sure, C. "Building On The CMS Strategic Vision: Working Together For A Stronger Medicare", Health Affairs Forefront, January 11, 2022. DOI: 10.1377/forefront.20220110.198444.

[3] 2022 State of Medicare Advantage Report. Better Medicare Alliance. Jul 2022. https://bettermedicarealliance.org/wp-content/uploads/2022/07/BMA-State-of-MA-2022-FIN.pdf.

[4] Medicare Advantage Outperforms Traditional Medicare on Cost Protections for Low- and Modest-Income Populations. ATI Advisory. Apr 2022. https://bettermedicarealliance.org/wp-content/uploads/2022/04/BMA-Medicare-Advantage-Cost-Protections-Data-Brief_FINv2.pdf.

[5] Freed, M., Biniek, J.F., Damico, A., Neuman, T. Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, Star Ratings. Kaiser Family Foundation. Aug 25 2022. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/.

[6] Positive Outcomes for High-Need, High-Cost Beneficiaries in Medicare Advantage Compared to Traditional Fee-For-Service Medicare. Avalere Health. Dec 2020. https://bettermedicarealliance.org/wp-content/uploads/2020/12/BMA-High-Need-Report.pdf.

[7] 2022 State of Medicare Advantage Report. Better Medicare Alliance. Jul 2022. https://bettermedicarealliance.org/wp-content/uploads/2022/07/BMA-State-of-MA-2022-FIN.pdf.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

- The number of MA plans offering expanded benefits such as access to meal and nutrition benefits, transportation, caregiver support, and telehealth grew by 43% in 2022.[8]

- **Driving high-quality outcomes and satisfaction**
  - Based on encounter and claims data from 2015 to 2017, when compared to Traditional Medicare beneficiaries, MA beneficiaries experienced:[9]
    - 43% lower rate of potentially avoidable hospitalizations
    - 57% lower rate of avoidable hospitalizations for acute conditions for beneficiaries with major complex chronic conditions
    - 41% higher utilization of primary care services and outpatient follow-up care for beneficiaries with major complex chronic conditions
  - In 2022, 90% of MA beneficiaries were enrolled in a 4 Star or above plan and nearly 27% were enrolled in a 5 Star plan[10]
  - In a 2022 survey of 2,800 MA enrollees, 88% stated that they were satisfied with their coverage, with 63% stating they were "very satisfied"[11]

- **Advancing access to care for minority and high-need populations[12]**
  - 99.7% of Medicare beneficiaries now have access to at least one MA plan
  - 33.7% of MA beneficiaries identify as racial and ethnic minorities compared to 16% of Traditional Medicare beneficiaries
  - 52.7% of MA beneficiaries live below 200% of the federal poverty level compared to 38.3% of Traditional Medicare beneficiaries
  - 30.3% of End-Stage Renal Disease beneficiaries are now enrolled in an MA plan

---

[8] Murphy-Barron, C., Buzby, E. Review of Contract Year Medicare Advantage supplemental healthcare benefit offerings. Milliman. Last accessed Aug 30 2022. https://bettermedicarealliance.org/wp-content/uploads/2021/11/Milliman-Issue-Brief-CY-2022-MA-Supplemental-Benefits_20211115112.pdf.

[9] Positive Outcomes for High-Need, High-Cost Beneficiaries in Medicare Advantage Compared to Traditional Fee-For-Service Medicare. Avalere Health. Dec 2020. https://bettermedicarealliance.org/wp-content/uploads/2020/12/BMA-High-Need-Report.pdf.

[10] 2022 State of Medicare Advantage Report. Better Medicare Alliance. Jul 2022. https://bettermedicarealliance.org/wp-content/uploads/2022/07/BMA-State-of-MA-2022-FIN.pdf.

[11] Spotlight on Medicare Advantage: An eHealth Survey. eHealth. Jun 2022. https://news.ehealthinsurance.com/_ir/68/20225/Spotlight_On_Medicare_Advantage_eHealth_Survey_June2022.pdf.

[12] 2022 State of Medicare Advantage Report. Better Medicare Alliance. Jul 2022. https://bettermedicarealliance.org/wp-content/uploads/2022/07/BMA-State-of-MA-2022-FIN.pdf.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

In 2022, more than 28 million beneficiaries (48% of the eligible Medicare population) were enrolled in an MA plan and it is anticipated that enrollment will increase as more seniors recognize the value of MA.[13] The 2022 Medicare Trustees Report projects that half of all Medicare-eligible beneficiaries will be enrolled in MA by 2026, with MA beneficiaries making up over 52% of the total Medicare population by 2030.[14] As more individuals choose MA, PDP, and MA-PD plans we believe that it is of the utmost importance that CMS promote stable payment and policies that allow plans to provide consistent value and high-quality benefits to the growing Medicare population.

In this Proposed Rule, CMS proposes several significant changes to advance health equity, address concerns with prior authorization, and eliminate deceptive marketing practices. We support the goals of many of these proposals, including:

- **Star Ratings:** Reducing the weight of patient experience/complaints and access measures from 4 to 2 to place greater emphasis on clinical outcome measures and better align with the weighting used under other CMS quality reporting programs. We recommend that CMS implement this policy for 2025 Star Ratings.
- **Health Equity:** Requiring that MAOs ensure that services are provided in a culturally competent manner to all enrollees and have a quality improvement program in place to reduce health disparities.
- **Marketing:** Requiring MAOs to have an oversight plan in place for reporting non-compliant sales agent activity to CMS and prohibiting unsolicited contact not initiated by a potential enrollee, including unscheduled door-to-door interactions.
- **Behavioral Health:** Allowing new behavioral health specialty types (Clinical Psychologists, Licensed Clinical Social Workers, and Prescribers of Medication for Opioid Use Disorder) to be eligible for the 10-percentage point telehealth credit in meeting network adequacy requirements, especially in light of ongoing workforce shortages.
- **Part D:** Expanding PDP flexibility to include interchangeable biologics, unbranded biological products and authorized generics to an approved formulary to provide beneficiaries with access to a new lower cost alternative as soon as possible.

However, when taking all proposals under this rule into consideration for the 2024 plan year, we are concerned CMS has not provided sufficient implementation time to plans. Throughout our comments, we describe how CMS' proposals, if finalized as proposed, will have an impact on current processes to help CMS better understand the cost and staffing impact to plans. With any change in CMS policy, CVS Health is committed to ensuring that we have the right staffing, expertise, processes, and infrastructure to support full

[13] Freed, M., Biniek, J. F., Damico, A., Neuman, T. Medicare Advantage in 2022: Enrollment Update and Key Trends. Kaiser Family Foundation. Aug 25 2022. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/.

[14] 2022 Annual Report of the Boards of Trustees to the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. See https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

compliance with CMS' requirements while maintaining a positive experience for our beneficiaries.

We are also concerned that CMS has not adequately considered the associated costs of implementing all policies. In the Regulatory Impact Analysis of this Proposed Rule, CMS acknowledges that there are proposals where the agency is unable to fully quantify the impact.

All Medicare and Medicaid plans must have actuarially sound rates. It takes time to understand new requirements and incorporate them into our plan design, so they can be adequately accounted for in our bids. Given all that CMS' is putting forward in this proposed rule, we urge CMS to carefully reconsider the magnitude of some of the changes it is proposing and to consider delaying or modifying certain proposals to support effective plan implementation. **Based on CMS' own analysis, the year-to-year expected average change in revenue between the 2023 Final Rate Notice and the proposed 2024 Advance Notice is a swing of -7.27% (last year CMS increased MA payments by 5% from 2022 to 2023, and now for 2024 CMS is cutting MA payment by -2.27% relative to 2023).** [15]

Aside from the costs of implementation, CVS Health is concerned that several proposals have the potential to disrupt plan stability and negatively impact the beneficiary experience without further clarification or reconsideration by CMS. Our most significant concerns focus on the following areas:

- **Star Ratings:** Modifying the hold harmless policy for the Health Plan Quality Improvement and Drug Plan Quality Improvement measures to apply only to 5-Star plans would effectively penalize contracts with 4 and 4.5 Stars when CMS considers 4 Stars to be reflective of Above Average performance. We are also concerned that the proposed removal of guardrails when determining measure-specific-thresholds for non-Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures will increase volatility in the Star Ratings program when more stability is needed. We believe that further improvements can be made to the Star Ratings program to better incentivize improvements in the clinical care of all beneficiaries, reduce volatility, and better capture the patient experience.
- **Prior Authorization/Utilization Management:** We are concerned that without additional clarification and implementation time, these proposals have the potential to negatively impact MAO's ability to ensure that beneficiaries receive safe, effective, high-value care. While we recognize CMS' intention of ensuring that MA beneficiaries have access to Medicare basic benefits, we request that the agency consider the challenges of these policies if finalized as proposed.
- **Revision of the "Gross Covered Prescription Drug Costs" Definition:** By revising the definition to exclude all direct and indirect remuneration, including manufacturer rebates received after point-of-sale, the proposed definition will disincentivize

[15] Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. https://www.cms.gov/files/document/2024-advance-notice.pdf.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

manufacturers from providing such rebates, which will have a major negative impact on the Part D program and government costs.

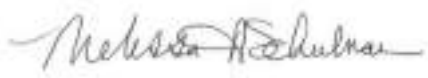
- **Medication Therapy Management (MTM) Program:** CMS should not move ahead with expansion of the MTM program in Part D as evidence supporting its effectiveness is currently limited. We support the goals of reducing medication errors, optimizing therapeutic outcomes and promoting consistent and equitable access to MTM services and offer CMS several suggestions on how to consider future expansion of an evidence-based program.
- **Marketing:** While we strongly support the intent of the marketing proposals and CMS oversight over deceptive marketing practices by plans, agents, and brokers, we are concerned that codifying waiting time standards and new requirements for advertising without further clarification or flexibility from CMS may have the unintended effect of creating a negative beneficiary experience.

As CMS considers comments to this Proposed Rule, we recommend that the agency continue working with MAOs, PDPs, and other stakeholders to further understand the impact of these changes and to focus on those policies that will definitively strengthen the MA and Part D programs for the millions of beneficiaries they serve.

A more detailed discussion of our recommendations is provided in the attached Appendix. Where additional subregulatory guidance is needed, we encourage CMS to announce formally in the Final Rule that it will use enforcement discretion as the agency develops further guidance and plans work toward these proposals.

Thank you for considering our recommendations and comments. CVS Health is committed to working with CMS as it formulates rules and policies that advance affordable, cost-effective care that provides beneficiaries with innovative choices of coverage that meets consumer needs. We welcome any follow-up questions you may have.

Sincerely,



Melissa Schulman
Senior Vice President, Government & Public Affairs
CVS Health

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

Appendix

Specific Comments on Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications Proposed Rule

I. Medication Therapy Management (MTM) Program (§ 423.153)

CMS is proposing changes to the MTM program targeting criteria to expand access to MTM services and to promote consistent and equitable access. These changes include requiring plan sponsors to target all core chronic diseases identified by CMS, lowering the maximum number of covered Part D drugs that may be required from 8 to 5 drugs and requiring that all Part D maintenance drugs be included in a sponsor's targeting criteria and lowering the cost threshold to be commensurate with the average annual cost of 5 generic drugs. CMS states that these changes would result in more Part D enrollees becoming eligible for MTM services and would also better align MTM eligibility criteria with statutory goals to reduce medication errors and optimize therapeutic outcomes for beneficiaries with multiple chronic conditions and taking multiple Part D drugs, while maintaining a reasonable cost criterion.

CVS Health supports CMS goals of reducing medication errors, optimizing therapeutic outcomes and promoting consistent and equitable access to MTM services. However, we have significant concerns that the proposed changes will not achieve these goals, but will instead simply vastly expand the program, dramatically increasing enrollment and cost with little or no proven benefit to members. CMS estimates that enrollment will more than double from 9% to 23% of Part D members. However, based on our initial analysis, Aetna's MA-PD plan MTM targeting will increase approximately tenfold, and across our PBM book of business the increase varies dramatically from between 15 to 60%, depending on the member population and type of plan. The increased costs would similarly be greater by orders of magnitude compared to CMS's estimate. For example, our preliminary estimate of the increased cost of targeting alone would be enormous—nearly $50 million for Aetna's MAPD plan population alone. This does not include the increased medication reviews, reports and other MTM services that would have to be similarly increased exponentially. Extrapolating this cost across the entire Part D population would easily dwarf CMS' cost estimate of a $336 million.

In simulating a subset of Medicare MAPD plans, we found the *average* qualification rate under the proposed NPRM targeting criteria was 25%; however, additional analysis at a contract level yielded a significant variation in the qualification rate with a range between 16% to 57%. Influencing these rates was the plan type, with DSNPs qualifying greater than 45% of their membership. The administrative cost will likely be unevenly spread and highly variable based on beneficiary demographic information.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

As noted above, the uneven distribution based on plan type unfairly burdens those plans with higher qualification rates and therefore increased administrative costs. The significant increase in the cost of providing MTM may result in increase in premiums.

We also believe CMS underestimates the time for a pharmacist or other qualified health care professional to complete the Comprehensive Medication Review (CMR). While the average CMR conversation with the enrollee may take 20-40 minutes, the pharmacist or other healthcare professional spends additional time reviewing the case before the conversation with the enrollee and preparing the post CMR materials. A better estimate of the time involved, and thus the cost, is 60 minutes per CMR conducted.

While some increase in cost may be justified based on evidence that increased enrollment will result in improved outcomes, CMS provides no such evidence. Even today at current enrollment levels, there has been little to no evidence that MTM programs are effective in reducing medication errors and improving health outcomes. While CMS postulates that published studies indicate that MTM services "may generate overall medical savings, for example, through reduced adverse outcomes including reduced hospitalizations and readmissions, outpatient encounters, or nursing home admissions," it goes on to acknowledge that it is, "unable to generate reliable savings estimates from the published studies due to limitations in potential study design, including the lack of a control group and numerous intervening variables."

Instead of simply ramping up enrollment in a program that is yet to demonstrate its effectiveness, a better approach would be to revisit the current MTM program to make changes that better integrate with the medical benefit, such as allowing direct reimbursement to pharmacists involved in the member's medical care team for their cognitive clinical services. While some changes may require the help of Congress, a retooling of the MTM program along these lines is more likely to achieve the end-goal of substantial, longitudinal medication management and improved outcomes than simply expanding the MTM program alone. The only sure outcome of the proposed changes will be to increase Part D program costs and premiums drastically at a time when these are already expected to increase due to finalization of the CMS rule on pharmacy price concessions and changes due to the Inflation Reduction Act of 2022.

MTM qualification criteria are designed to identify patients who would derive the greatest benefit from a CMR and ongoing Targeted Medication Reviews (TMRs). Targeting criteria currently allows plans the flexibility to tailor their chronic conditions to meet the needs of their population and those beneficiaries with complicated medication regimens and the most expensive drug therapies.

We agree with standardizing qualification criteria across all plans by removing a plan's ability to only target specific conditions; however, we caution against overly broad criteria that captures beneficiaries who are not likely to benefit from services. Codifying the current nine chronic conditions and adding HIV/AIDS would prevent plans from unfairly manipulating their targeting criteria for the purpose of decreasing their Star measure

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

denominator. Within the required conditions, we would recommend allowing plans the flexibility to select one condition each under the Mental Health, Lung Conditions, and Bone Disease categories to continue tailoring to the needs of their populations.

We do not recommend adding Cancer as a chronic condition. This category does not lend itself to meaningful clinical interventions by an MTM provider. Beneficiaries under the current qualification criteria who are subsequently taking oncology drug(s) would still benefit from the MTM consultation as a review for side effects, safety, and potential drug-drug interactions.

We do not recommend decreasing the maintenance medications from 8 to 5 because beneficiaries who participate in the MTM program should be those with higher pill burden and complicated medication regimens.

We do not recommend decreasing the cost threshold to align with annual generic medication costs because that would target beneficiaries who would not benefit from a CMR consultation regarding cost savings opportunities.

Finally, if CMS does move ahead with its proposed changes to the MTM program, changes of this magnitude would constitute a substantial change to the MTM Star measure, including changing the targeted population and measurement. Historically, when significant changes have been made to other Star measures, these measures have moved to the Display Measure page for two (2) years.

Because the proposed changes impact all aspects of the targeting algorithm, it will be difficult to assess the impact of this targeting on the number of CMRs the plans will be able to complete. The expanded enrollment will include types of enrollees not previously targeted and for whom plans do not have the experience to understand how and if this new population of beneficiaries will engage in a CMR.

Increasing qualification will result in plans needing more total CMRs to achieve a 4- or 5-Star rating. Combined with the potential increased cost, increasing the number of enrollees targeted will have an impact on the percent of CMRs completed. In the proposed rule section on MTM costs, CMS notes that it expects 36.5% of enrollees to decline a CMR. This expectation is not consistent with the CMR completion rates for the 4 and 5 star cut points.

Recommendations:

- **CMS should not move ahead with expansion of the MTM program unless and until there is evidence supporting its effectiveness in achieving its intended goals, in which case any expansion should be more measured, particularly in light of the wide variation in potential impact**
- **If CMS moves forward with some or all of the proposed targeting changes, move CMR completion to a Display Measure for 2 years due to the significant change in targeting and thus impact on CMR completion rates**

CVSHealth
1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

- **Delay change in targeting**
- **Recommend only expanding the conditions targeted to all 10 proposed core conditions to see if that improves MTM engagement. Allow the plans some flexibility in how they target within broad therapeutic categories such as bone disease/arthritis or respiratory diseases, such as allowing plans to select specific conditions within these broad categories, so that the targeting isn't overly broad.**
- **Suggest a Stakeholder meeting to brainstorm potential improvements in MTM program**

II. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System ("Star Ratings") (§§ 422.162, 422.164, 422.166, 422.260, 423.182, 423.184, and 423.186)

We support CMS' efforts to create a resilient, high-value health care system that promotes quality outcomes, safety, equity, and accessibility for all individuals. However, as we have previously drawn to CMS' attention, tweaking cut points and guardrails do not and cannot address the larger methodological issues raised by CMS' benchmark-based Star Ratings program. Inherent in the current model is volatile and unpredictable scores. We continue to believe that CMS should consider alternative models to measure performance and would welcome the opportunity to work with CMS in developing alternatives that reward plans that provide quality, safe, equitable and accessible benefits. For example, CMS could move toward a set of measures with defined excellence standards (i.e., 4- and 5-star thresholds) for long-tenured measures backed by years of clinical data, experience, and best practices.

Our comments on specific proposals follow.

A. Reducing the weight of patient experience/complaints and access measures to further align the Part C and Part D Quality Rating System with other CMS quality programs

CMS proposes to lower the measure weight of the of patient experience/complaints and access measures from 4 times to 2 times for 2026 Star Ratings (2024 measurement period). CMS believes that reducing the weighting to 2 for this category of measures would align the patient experience/complaints and access measures more closely with the CMS Quality Strategy and other quality programs. CMS also recognizes that high-value care does not always align with patient experiences of care, further justifying this change.

CVS Health strongly supports reducing this measure weight to 2 times due to the unbalanced impact of the increased weighting of surveyed patient access and experience measures versus reflecting better health outcomes. However, CMS does not explain why this change should be delayed to 2026. We do not believe that CMS should wait until 2026 to make this change—this is a proposal that CMS should adopt for the 2025 Star Ratings (2023 measurement).

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

As shared in prior comment letters and other correspondence, the current weighting combined with relatively tight measure-level cut points creates a volatile outcome where relatively minor changes in member perspective year-to-year can significantly move the star ratings and create significant hardships and instability for millions of members as benefit plans in the following year must be significantly reduced in order to submit an actuarially sound bid. Benefit reductions taken due to lower CAHPS scores typically impact an additional year of Star Ratings as benefit reductions triggered by lower star ratings impact beneficiary perspectives on overall rating of health plan, ease of getting needed care, and other care access measures. Delaying this change will just multiply how many beneficiaries are impacted.

Therefore, it is CVS Health's position that CMS should adopt this proposal for the 2025 Star Ratings (2023 measurement).

- **Recommendation: CMS should finalize reducing the weight of patient experience/complaints and access measures to 2 times, but should implement this change one year earlier, for the 2025 Star Ratings.**

B. Removing guardrails when determining measure-specific cut points for non-Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures.

CMS proposes to remove guardrails for non-CAHPS measures, as it believes that the guardrails are no longer necessary due to adding the Tukey outlier deletion to the hierarchical clustering methodology to improve the predictability and stability of cut points, which will be implemented for the 2024 Star Ratings.

CVS Health opposes this proposal. As CMS notes in the preamble, the intent of guardrails was to improve predictability and stability of cut points year over year. CVS Health has previously commented on our concern with drastic movement of cut points and we believe that removing these guardrails is premature and may lead to further volatility.

Tukey's fences primarily remove the lower-end outliers, causing unpredictable movement of cut points in an upward direction outside of industry average movement. The current clustering methodology is inconsistent and does not provide the necessary stability, with or without Tukey and guardrails, that is needed. For example, cut points for MAPD Diabetes adherence moved over 2 times the industry average for 2022 Star Ratings, showcasing that the existing clustering algorithm is not consistently aligned with industry performance. Implementation of Tukey's without guardrails would further increase the cut points outside of industry average performance and further exacerbate this phenomenon.

In the alternative, CVS Health would support CMS removing the guardrails after it determines, for established measures, what truly reflects quality performance and produce set cut point(s) based on that data. For example, the current adherence measures are mature, and performance has begun to consolidate across the industry. There is an

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

opportunity for the establishment of set static cut points for these and other mature measures based on clinical and operational measurement guidelines. Setting these cut points would reduce uncertainty and volatility, while incentivizing performance improvement across core clinical measures of the Star Ratings program. CVS Health recommends the following measures for consideration and welcomes further conversation with CMS on this alternative proposal:

- **Breast cancer screening**
- **Colorectal cancer screening**
- **Osteoporosis Management in Women who had a Fracture**
- **Diabetes Care – Eye Exam**
- **Diabetes Care – Blood Sugar Controlled**
- **Medication Adherence for Diabetes Medications (formerly Part D Medication Adherence for Oral Diabetes Medications)**
- **Medication Adherence for Hypertension (RAS antagonists) (formerly Part D Medication Adherence for Hypertension (ACE or ARB))**
- **Medication Adherence for Cholesterol (Statins) (formerly Part D Medication Adherence for Cholesterol (Statins))**

For new measures or measures that demonstrate instability over time, CVS Health encourages CMS to continue to explore other classification methods such as Isolation Forest, DBSCAN, or k-means clustering and engage a Technical Expert Panel to review and reconsider long-term solutions and implications of varying methods for Star Ratings assignment.

- **Recommendation: Do not finalize the proposal to remove guardrails. If CMS finalizes this proposal, the agency should provide static measure cut points for the clinical measures listed above that have been in the program for over a decade and therefore have reached established standards of excellence supported by CMS data.**

C. Modifying the hold harmless policy for the Health Plan Quality Improvement and Drug Plan Quality Improvement measures.

CMS proposes to revise its current policy and apply its current hold harmless provision—which relates to two quality improvement measures and is applied to 4+ Star contracts—only to 5 Star contracts. CMS reasons that the hold harmless provision for the highest rating is not needed for 4- and 4.5-star contracts because they still have the potential to increase scores across measures and thus their Star Ratings.

CVS Health does not support this proposal. CMS considers 4 Star contracts to be reflective of Above Average performance. CMS' proposal would effectively penalize plans that have achieved what is recognized as high-quality performance. This proposal would disproportionately disadvantage larger contracts that already face challenges reaching above 4.5 Stars due to the size and diversity of needs in the populations they serve.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

Moreover, we are concerned that continued volatility in Star Ratings cut points and future policy changes impacting measures (e.g., IRA implementation and the impact on Part D measures) could make it increasingly difficult for plans to reach 5 Stars.

- **Recommendation: Do not finalize this proposal and maintain the hold harmless policy for contracts with 4 Stars and above.**

D. Creating the Health Equity Index (HEI) Rewards.

CMS proposes to reward plans that achieve high scores for enrollees with certain social risk factors. Currently, social risk factors are addressed by on adjusting for the average within-contract disparities in performance through the Categorical Adjustment Index (CAI), in order to not penalize or reward health and drug plans for factors that are difficult for plans to control. However, CMS notes that the CAI does not incentivize contracts to focus on reducing disparities. CMS has therefore developed the HEI to improve health equity by incentivizing MA, cost plan, and PDP contracts to perform well among enrollees with specified social risk factors. CMS further notes that the HEI does not replace the CAI and CMS does not propose to change the current CAI with the implementation of the HEI.

CVS Health supports CMS' desire to reward contracts that are successful with enrollees with social risk factors. We are committed to advancing health equity for our customers, colleagues, clients and communities by improving trust, health care access and quality of health for every population we serve. We recognize that it is critical to understand the challenges of our members with social risk factors in order to assist them with their health.

CVS Health is strongly committed to addressing health care disparities. For example, CVS Health has a platform that includes tools to help employers with Aetna plans track the impacts of the social determinants on their healthcare costs, provide valuable information to CVS to evaluate what interventions may be most useful to specific populations, as well as funding for affordable housing, and community outreach programs to assist with activities of daily living such as healthy eating, financial literacy and health information navigation. CVS Health is increasing its investments and working with clients to create health equity strategies for members with certain conditions that disproportionately affect patients of color and working with local community organizations and advocacy groups to ensure those facing health inequities have access to the resources and care they need. CVS Health has also launched Health Zones, a new nationwide initiative of concentrated local investments design to reduce health disparities and advance health equity in high-risk communities across the country. These are just a few examples of CVS Health's commitment to advance health equity.

However, we are concerned that the HEI reward will in practice duplicate, replace or adjust the CAI. In our experience the CAI has not delivered equity across plans; plans with higher proportions of dual eligible or LIS enrollees have lower average Star Ratings than those with lower proportions of those same beneficiaries. This HEI proposal does not appear to address this fundamental issue, but instead may result in some adjustment on the margins.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

We need more information from CMS to be able to respond to this proposal thoughtfully and completely. We understand that CMS intends to calculate measure-level scores for each contract among enrollees with the included social risk factors over the two most recent measurement years and that CMS has proposed reliability and contract size standards. We request CMS provide additional information regarding the methodology, the reward and the alternative reward structures that CMS is considering. We note that the results of this new measure are largely unknown and there is the potential for a negative impact to plans that do not meet the threshold. Therefore, similar to the information provided for Tukey's outlier calculations earlier this year, we request that CMS consider providing simulations to health plans to assess the impact of these ratings. This will allow plans to identify strengths and opportunities to better understand how to help their members with social risk factors. We also recommend modeling side-by-side HEI data with Reward Factor for 2+ years to understand impact to Star Ratings. In addition, we recommend adding as a display page component for two years in a similar fashion to how substantive measure-level changes are treated.

Recommendations:

- **CVS Health supports continued work toward the adoption of a methodology that would reward plans for work towards advancing heath equity. However, we oppose implementation of the HEI as proposed until further testing can be done to ensure that it will not result in unintended disproportionate impacts.**
- **Additionally, we do not support CMS' proposal to remove the reward factor and replace it with the HEI.**
- **We request additional information from CMS regarding the methodology, the reward and the alternative reward structures that CMS is considering.**
- **CMS should provide simulations to health plans (similar to the information provided for Tukey's outlier calculations).**
- **CMS should also model the HEI data with the Reward Factor for at least 2 years and add a display page component for two years (like substantive measure-level changes are treated).**

E. Removing the 60 percent rule for the adjustment for extreme and uncontrollable circumstances (adjustment for disasters).

Currently CMS excludes certain affected contracts from non-CAHPS measures during certain extreme and uncontrollable circumstances (the 60 percent rule) to ensure that the impact of those circumstances does not have an impact on cut points or reward factors for other contracts. Further analysis by CMS has revealed this rule can have an unintended adverse effect when the extreme and uncontrollable circumstances affect nearly all contracts (such as with the COVID public health emergency). CMS proposes, beginning with the 2026 Star Ratings, to remove the 60 percent rule.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

- **Recommendation: Finalize the proposal to remove the 60 percent rule for contracts impacted by extreme and uncontrollable circumstances.**

F. Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR)

As discussed earlier in our comments, CMS proposes significant changes to the MTM program targeting criteria to expand access to MTM services and promote consistent and equitable access. These changes will drastically increase enrollment in these programs. If CMS finalizes the changes to the MTM program as proposed, we recommend that CMS also move the MTM Program Completion Rate for Comprehensive Medication Review to a display measure for the 2026Star Ratings. This would ensure that plans are not unintentionally penalized on this measure due to the significant changes to the program.

- **Recommendation: If CMS finalizes the policy changes to MTM enrollment, move the MTM Program Completion Rate for CMR to the display page for 2 years due to substantive measure change.**

G. Medication Adherence for Diabetes Medications, Medication Adherence for Hypertension (RAS antagonists) and Medication Adherence for Statin Medications

CMS proposes to use risk adjustment based on socio-economic status for adherence measures, to apply continuous enrollment (CE) instead of member-years adjustment in the 2024 measurement year (MY), and no longer adjust for stays in inpatient settings and skilled nursing facilities beginning with the 2026 MY.

CVS Health needs additional information and analysis to weigh in on this recommendation. It remains unclear how CMS will account for medications distributed during an inpatient hospital or skilled nursing facility stay within the new measurement as the Part D benefit is not utilized during these stays. With cut points and industry performance consolidating recently, a handful of inpatient members that appear non-adherent due to these stays could impact a plan's performance for these measures and negatively impact a plan's ability to receive quality bonus payment.

In addition, display page results are available several months later than the Star Ratings, therefore, CVS Health recommends a minimum of three years on the display page to allow for adequate review and impact assessments for these heavily weighted measures.

CVS Health supports the change to continuous enrollment instead of member years as established relationships with members and health plans are crucial to success in these measures.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

CVSH requests additional information regarding how the new measurement criteria will be compared to prior years within the Drug Plan Quality Improvement measure upon year of implementation.

- **Recommendation: Do not finalize risk adjustment changes to these two measures until additional information on the methodologies can be provided to plans and concerns around medications distributed within inpatient settings can be properly addressed**

H. Polypharmacy Measures

CMS proposes to move the Part D Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults, and the Part D Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults measure from display measures to the Star Ratings. We are concerned about this change. It is unclear what the goal of including these measures is and we continue to believe it would be inappropriate to include Polypharmacy measures in future Star Ratings. There are instances when polypharmacy, or concurrent drug use, is clinically appropriate, but plan sponsors are not fully positioned to differentiate clinically inappropriate polypharmacy. Additionally, plan sponsors have little influence over the provider practice pattern of prescribing medications concurrently. As a result, a plan's performance on the polypharmacy measures would largely be outside of its control. If CMS wants to include these measures in the program in future years, one alternative could be to redesign the measure to only assess new starts, as this would provide a baseline for the measurement of further risk or decline.

- **Recommendation: Maintain the polypharmacy measures as display measures only.**

I. Concurrent Use of Opioids and Benzodiazepines

CMS proposes to add the Concurrent Use of Opioids and Benzodiazepines (COB) to the 2026 Star Ratings because CMS believes that this measure will help plans identify enrollees who are at risk. CMS also noted that the overall rates for the COB measure (on the display page) have improved slightly year over year.

CVS Health does not support this proposal. Plans have minimal ability to impact this measure as it depends on physician behavior. An additional concern is the methodology, since new members and those changing plans will appear as initial fills when they are not actually initial fills.

- **Recommendation: Do not include the COB measure in future Star Ratings.**

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

III. Prior Authorization and Utilization Management Requirements (§§ 422.101, 422.112, 422.137, 422.138, and 422.202)

CMS proposes that coordinated care plans may only use prior authorization to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary based on standards in the proposed rule. We would emphasize that a study of Aetna's Medicare Advantage population showed that the majority of medical necessity denials were driven by Medicare's coverage rules (85%), not unnecessary barriers erected by plans.[16] Thus, we believe that some of CMS' proposals are misplaced and discuss this further in our comments to the proposals in this section.

To begin, CVS Health believes that prior authorization and utilization management are important tools to ensure enrollees receive medically necessary care. CMS has recognized this same value, implementing prior authorization and pre-claim review for select hospital outpatient services, ambulance transport, and DMEPOS items under Medicare fee-for-service.

That being said, we support efforts to make the prior authorization and utilization management process more streamlined and efficient for plans, providers, and patients. We support the move toward electronic prior authorization (ePA) and believe that it can resolve many of the issues that have been recently discussed related to prior authorization. For example, there is concern that prior authorization leads to delays in care; however, some prior authorization delays are a result of the plan receiving insufficient information from the provider. In some cases, this may result in an initial denial that is later overturned once sufficient information is submitted. We recognize that providers may be frustrated when asked for additional information. Electronic prior authorization can be designed so the initial provider request cannot be submitted until all of the necessary information is obtained. This means that a single request is handled once, instead of multiple times by the provider and the plan. Electronic prior authorization would be a more effective, less disruptive and less costly solution to prior authorization concerns.

CVS Health is also working on comments to the Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule (CMS-0057-P) which if finalized, would go into effect in 2026. That rule would set interoperability standards for MAOs that would support the efficient exchange of information between plans, providers, and patients that is central to many proposals of this proposed rule.

- **Recommendation: We encourage CMS to consider delaying implementation of proposals under this rule until at least 2026 to align with the effective date of the interoperability rule. This would ensure that plans have sufficient time to ensure that the technical, staffing, and resource infrastructure is in place to effectively support the changes under this proposed rule.**

[16] Schwartz, Chen, Jagmin, et. al,, Coverage Denials: Government and Private Insurer Policies for Medical Necessity in Medicare, *Health Affairs* 41, No. 1 (January 2022).

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

A. Limiting Utilization Management and Prior Authorization

CMS proposes that coordinated care plans may only use prior authorization to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary based on standards in the proposed rule.

CMS also proposes to require MA Plans to comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare statutes and regulations as interpreted by CMS. As CMS says, "In other words, an MA plan would not be permitted to deny coverage of a Medicare covered item or service based on internal, proprietary, or external clinical criteria not found in Traditional Medicare coverage policies." However, MA organizations may create internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature that is made publicly available to CMS, enrollees, and providers if there are no established coverage criteria.

CVS Health appreciates CMS' efforts to ensure that Medicare beneficiaries receive all the benefits to which they are entitled and to receive those benefits without undue delay or trouble. However, when items and service are not already subject to an NCD or LCD, CMS' proposal will limit MA plans' ability to be effective stewards of federal dollars—the Medicare Trust Fund—and lead to unnecessary services and costs to beneficiaries because the proposal would prevent MA plans from reviewing certain items and services before they are received. Even if plans cannot review items and services beforehand, MA plans are required to ensure that the items and services are medically necessary, including whether the items and services were reasonably necessary based on the enrollee's medical; without prior review, inappropriate services can only be denied post-service. This means that the provider will not receive compensation for items and services already provided; providers may be reluctant to contract with MA plans as a result. Fewer providers in MA plans means fewer options for beneficiaries, possibly delayed care and network adequacy issues at a time when CMS is working to strengthen patient access through reduced wait times and additional network adequacy standards. Importantly, the Medicare beneficiary may also have received, and paid cost-sharing for, inappropriate or unnecessary care.

In fact, in a study of Medicare Advantage beneficiaries in Aetna plans (between 2014 and 2019), over 5 million claims were denied (over $416 million dollars in claims) **post-**service as a result of Medicare's medical necessity criteria. Of the services denied because of Aetna's rules, the most common reason for the denial was that the services were experimental/investigational or without proven efficacy. As the study notes, coverage policies can provide "nuanced incentives based on evidence-based determinations of medical necessity."[17] There is every reason to believe that the amount of medically **un**necessary services received would increase if MA plans are limited in the utilization

[17] Id.

CVSHealth
1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

management processes they may employ to ensure that services are medically necessary **before** they are received.

MA prior authorization and other pre-service medical management requirements are designed by MA plans when NCD and LCDs do not apply, in order to ensure quality, safety, and appropriateness under a managed care model. While Medicare may cover spinal surgery in certain circumstances, best medical practice and the most conservative and safe approach based on clinical evidence may be to try physical therapy before surgery. Based on our understanding of this proposed rule, MA plans would be limited in their ability to perform pre-service review, which leaves post-service or retrospective review, as the primary way MA plans can effectively assess the quality, safety, and appropriateness of a service. We are concerned because if an MA plan is only permitted to review the treatment after it is received, this significantly limits the plan's ability to intervene and avoid potentially dangerous or low-value care before it is provided.

Upon retrospective review, an MA plan may conclude that surgery was not medically appropriate (and therefore not necessary)—and deny coverage—leaving the beneficiary worse off (because they received an inappropriate and invasive level of service) and leaving the provider worse off because the claim was denied. In other words, if, because Medicare covers spinal surgery, an MA plan cannot direct beneficiaries first to less costly and less invasive treatments, beneficiaries lose an important safety net, providers may be facing more claims denials, and the Medicare program loses as well. Services that are covered by Medicare, and may be appropriate for some beneficiaries, may not be the most appropriate service for any particular beneficiary at the time of service.

Similarly, the service may be appropriate, but the provider may be out-of-network. The beneficiary may choose out-of-network services (depending on their plan design), but they should do so with the awareness that the services are out-of-network and may therefore incur higher out-of-pocket costs. Prior authorization avoids out-of-network surprises and the plan can coach and help its beneficiaries to further understand options to consider. It also ensures that out-of-network facilities meet quality and safety standards; beneficiaries may choose their provider, but prior authorization can help ensure that they do not choose ineffective or dangerous services.

We also note that CMS has increased case management requirements for MA plans over the years; CMS believes, and we agree, that case management ensures that beneficiaries receive necessary care and that care is coordinated among disparate providers. Utilization management plays an important role in case management, to ensure that beneficiaries receive the best treatment for them at that time the treatment is necessary. Limiting utilization management may thus limit the value and protection that case management may add for certain beneficiaries. For example, Medicare places benefit period limits on certain services, such as SNF care. After the 100th day of SNF care, the beneficiary must pay all of the costs on their own. An MA case manager can review the treatment plan and ensure that the beneficiary is not placed in SNF care inappropriately and possibly exhausting their benefit period coverage before their benefit need has been met. A beneficiary facing large

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

out-of-pocket costs after an unnecessary extended (or serial) SNF visit is not well served by the provider, plan or program if some of the SNF visit could have been avoided.

In addition, MA utilization management also prevents fraud before Medicare beneficiaries and the Medicare program are taken advantage of by unscrupulous providers and vendors. This protects beneficiaries and the integrity of the program. CMS will be forced to pay MA plans more to cover the costs that MA plans could have avoided with appropriate utilization management, including prior authorization, adding costs to the Medicare program.

We also are concerned that CMS has not appropriately considered the costs of its utilization management proposals. Not only will reduce utilization management result in payment for items and services which were not clinically appropriate, but the proposal to extend prior authorization approval and establish a Utilization Management Committee will be expensive. CMS should carefully consider whether the benefits of this proposal will outweigh the costs.

We want to emphasize that our plans do not use utilization management, including prior authorization, to limit access to medically necessary care. As CMS has discovered through its Recovery Audit program, there simply are times when a Medicare beneficiary receives covered benefits in a medically unnecessary setting.[18] Prior authorization is designed to catch these issues before a service is performed so a beneficiary can receive care in the most appropriate setting.

We typically approve 85-90% of all prior authorization requests under our Aetna Medicare plans. Such a high approval rate demonstrates that we do not use prior authorization to limit access. But it also demonstrates that a significant percentage of item and service requests (up to 15%) are not appropriate—the item/service may not be suitable for the beneficiary, or the item/service may not be covered, or the item/service is not medically necessary. Limiting prior authorization and other medical management techniques will lead to more unnecessary or inappropriate care.

Although we appreciate that there has been a great deal of attention paid to utilization management in Medicare, and a great deal of criticism of its use, our plans strive to ensure that the beneficiaries in our plans receive the most appropriate service in the timeliest manner; effective and cost-efficient care ensures our members stay as healthy as possible, and our stewardship of the Medicare program ensures that it stays healthy as well. We succeed when our members live vibrant, healthy lives; erroneously limiting or denying medically necessary care does not serve our mission and we do not do it.

We support a prior authorization program that promotes quality, affordable health care, and reduce unnecessary administrative burdens for both the health insurance issuer and the health care provider. We also agree that the process should be simple, straightforward and clear. We recognize that CMS' intention is to ensure that MA beneficiaries receive benefits

[18] *Fact Sheet: Two-Midnight Rule*. Centers for Medicare & Medicaid Services. https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

that are covered under original Medicare. However, we are concerned that the proposed changes under this section create areas of uncertainty that may lead to excessive limitations on the use of prior authorization, which would increase costs and remove safety and fraud-prevention guardrails.

Recommendations:

- **We recommend that CMS further clarify its intended goals of the proposed changes to §422.101 to avoid excessive limitations on plans' ability to utilize pre-service review and utilization management to ensure that beneficiaries are receiving quality, medically necessary services.**
- **Accelerate the adoption of electronic prior authorization and work with stakeholders to streamline prior authorization processes that ensure safe, affordable care.**

B. Approval Duration

CMS proposes to require that a prior authorization approval must be valid for the duration of the approved course of treatment and that plans provide a minimum 90-day transition period when an enrollee who is currently undergoing a previously approved treatment switches to a new MA plan. While we support the goals of this proposal and continuity of care for beneficiaries, we have several concerns, particularly with regard to the minimum 90-day transition.

First, CMS does not appear to address a scenario where the planned duration of the treatment is unknown at the time when coverage is requested. CMS also does not address a scenario where it is permissible for two MA plans to utilize internal coverage criteria in the absence of a standard under original Medicare. In both of these instances, a new MA plan may be held responsible for the long-term cost of care provided by an out-of-network provider, or for a treatment that may not meet the standards of their internal coverage criteria where such criteria is consistent with CMS policies, but utilization management may vary. These concerns become a greater priority as the number of high-cost and experimental treatments continue to increase.

We also note that a 90-day transition period for medical benefits under MA is quite different from a 90-day transitional fill requirement for Part D covered drugs. Medical treatment plans may be extensive, complicated and, as a result, very expensive. In addition, if a member changes plans, the resources available to the member—including the facilities and providers available—may mean that the care plan should be revised to better utilize the new resources available.

Second, CMS failed to clarify this 90-day transition proposal would not apply to supplemental benefits, as this varies from plan to plan. However, covering only Original Medicare benefits and not others would likely be confusing to beneficiaries, especially if

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

CMS puts language in an EOC. CMS would need to address and carve out supplemental benefits that are in the same section of the EOC.

While we generally support continuity of care through the 90-day transition period for basic benefits, we recommend that CMS clarify this policy to allow plans to do the following at the end of the 90-day transition period for basic benefits: (1) for services provided by an out-of-network provider, the new plan can apply out-of-network limits if the beneficiary is informed that the provider is out-of-network, chooses to continue receiving care from that provider and does not switch to an in-network provider; and (2) for treatments extending beyond 90 days where the new plan utilizes its own prior authorization and utilization management criteria, the new plan is permitted to conduct a new review and issue a new decision to go into effect at the end of the 90-day transition period.

These should be communicated to the beneficiary within the 90-day transition period to allow for sufficient notification and planning. Ideally, conversations about a beneficiary's long-term treatments should also take place as part of the enrollment conversation to ensure that the beneficiary selects the best plan to meet their needs.

Recommendations:

- **We support the goals of ensuring continuity of care for beneficiaries. However, we believe that this proposal requires significant operational considerations that make implementation in 2024 difficult. We recommend that CMS finalize this proposal with an effective date of 2026 to align with the effective date of the interoperability standards. In the interim, we request CMS to provide further guidance on this policy, especially as it relates to permissible actions by plans after the 90-day transition period ends.**
- **CMS should clarify that the 90-day transition period applies only to basic benefits and not to supplemental benefits.**
- **CMS should allow plans to conduct their own prior authorization or utilization management review for treatments extending beyond the 90-day transition period. Plans should also be permitted support beneficiary transition to an in-network provider at the end of the transition period.**

C. Establishing a Utilization Management Committee

CMS would also require MA plans to create a new Utilization Management Committee to review all utilization management policies annually and ensure they are consistent with current, traditional Medicare's national and local coverage decisions and guidelines. The Utilization Management Committee would be required to include a majority of members who are practicing physicians, include at least one independent practicing physician, and including members representing various clinical specialties.

MA plans already have numerous multidisciplinary committees and medical advisory boards that review utilization management and other MA policies; these committees include

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

practicing health care providers and some committees may even include independent providers. Plans currently use these committees for the review of clinical data and literature, as well as various quality and compliance tasks; CMS' proposal would add an unnecessary layer of complexity on these already functioning groups that is duplicative and unnecessary. While we support the concept of an annual review of all prior authorization and utilization management policies, we believe that plans should also have the flexibility to use current committees and processes to perform these functions. For example, CMS appears to be requiring any prior authorization used by a plan to be reviewed before use, but most of these policies are already currently in use. Supplemental benefits may not have specific prior authorization policies, but plans have internal policies and guidance documents to properly ensure that the correct members receive the benefit; it is unclear if CMS believes those policies are utilization management policies and if so, if they would have to be reviewed before implementation.

In addition, CMS' proposal to include independent providers on the new Utilization Management Committee will create challenges, especially if this is a requirement for 2024. As a requirement that goes into effect for all plans at the same time, we anticipate there will be competition among MA plans to recruit the requisite independent physician. There is a limited number of providers that meet the required criteria and they may have limited time and resources to devote to this task. We support CMS' requirement that these physicians be free of conflict; however, many independent physicians serve as advisors to multiple companies and organizations, including other MA plans and manufacturers of treatments and therapies that may be the focus of certain polices.

CMS would also require the Utilization Management Committee to have a majority of "practicing" physicians serving on the Committee, but CMS does not define "practicing." If CMS considers "practicing" to mean actively seeing patients, there will be even fewer physicians available to sit on these all of these new committees. As a result, we recommend that CMS revise the regulatory text to require that the clinical members be "appropriately licensed and skilled physicians or other qualified health care providers".

We recommend that the composition of the committee reasonably represent multidisciplinary clinical specialties with expertise in the types of claims that the MA plan typically receives. In other words, MA plans should have discretion with respect to the types and numbers of physicians (external and internal); the inclusion of qualified non-physician health care providers such as pharmacists, nurses, and licensed clinical social workers; and qualifications (currently practicing, specialty, education, etc.) of those that serve on the Committee; provided that the plan's Committee reasonably represent the experience, skills and independence needed to competently review the plan's utilization management policies.

CMS also would require all prior authorization policies to be reviewed by the Committee before the policies could be put into place. However, this overlooks the fact that policies are changed throughout the year—new drugs may be introduced, new LCDs are issued, new treatments developed. Of particular note, LCDs are not always released in advance of

CVSHealth
1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

changes. They may be published with retroactive changes and the same LCD can receive multiple updates within the year. If the Committee must review and approve every prior authorization policy, the Committee effectively must be active year-round and in the case of an LCD that is published that is retroactive, there is no ability for the Committee to review it prior to its effective date. In addition, the fact that this Committee must convene for "new" LCD releases and other changes, further limits the personnel that can commit to serving on the Committee and adds further administrative costs.

Recommendations:

- **Permit MA plans to use preexisting committees to complete the required prior authorization policy review. In the alternative, revise the regulation to read as follows:**
  - *(c) Utilization Management Committee Composition. The MA plan must establish a Committee that includes appropriately licensed and skilled physicians or other qualified health care providers. The MA plan has discretion on the types and numbers of external physicians or qualified health care providers that serve on the Committee and discretion in setting reasonably representative qualifications for all individuals that serve on the Committee, provided that the MA plan ensure that various clinical specialties and a wide range of conditions are considered in the development of the MA plan's utilization management policies.*
- **Do not require the Utilization Management Committee to review and approve all prior authorization policies before they are implemented; doing so would require that the Committee meet constantly to review policy updates as Medicare LCDs that are updated on a rolling basis**
- **Provide plans with additional time to recruit, select, and onboard independent providers for the Utilization Management Committee or existing committees serving the function of the Utilization Management Committee.**

D. Specific Concerns for Utilization Management with Part B-covered Drugs

We want to call special attention to CMS' proposal on Medicare Part B drugs. As with physician services, we use utilization management when there is a clinical reason to do so; for example, to ensure the drug is only continued if it is effective, to ensure an IV route of administration is not used excessively when treatment guidelines recommend a switch to subcutaneous, which is covered by Part D and we already follow applicable NCDs and LCDs. We appreciate that CMS clarified that step therapy will continue to be permitted if it does not conflict with step therapy that is either included or specifically disallowed in an applicable NCD or LCD.

We use our pharmacy benefit manager to ensure Part B drugs are covered appropriately. Part B drugs may be effectively managed through a P&T committee structure, but such a structure is not suited for Part C medical reviews. Members of a P&T committee do not have the necessary expertise for Part C medical reviews and adding the necessary expertise

CVSHealth
1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

would make the P&T committee far too big to effectively function. In addition, if Part B drug utilization is reviewed by both the P&T committee and the newly required Utilization Management Committee, there may be conflicting policies and instructions. At a minimum, CMS should allow Part B utilization management to be managed under current P&T processes and removed entirely from this proposal.

If CMS moves forward with its prior authorization proposals and includes Part B, CMS should clarify that pharmacists are qualified health care providers that are sufficiently knowledgeable and skilled to make prior authorization determinations. This clarification should be included in the regulatory text.

Regarding the proposed requirement to publicly post UM criteria, we support increasing transparency. However, we believe the content requirements for Part B drug UM criteria documents should more closely align with those of Part D drugs which are already required to be publicly posted. Although CMS has calculated the level of effort needed for plans to upload criteria documents to their websites, the agency has not accounted for the effort needed for plans to expand the amount of information included in their criteria documents. It is common for these documents to include the coverage criteria for the drug, the approval duration(s), and a reference list. It is less common to include a summary of each citation referenced or the rationale for adopting the policy. Adding this level of detail to existing Part B drug criteria documents and maintaining it over time will require a significant level of effort. Moreover, we do not believe this level of detail for drug criteria documents is needed or desired by providers. In our experience, the average Part D drug criteria document is 1-2 pages long while the average drug criteria document of the type outlined in the Proposed Rule averages 10-15 pages. Many are quite longer. We recommend requiring Part B drug criteria documents to be publicly posted within the proposed timeframe but allowing plans to use their current format so long as a reference list is included. Omitting the detailed information summary and rationale for adopting the policy will balance the need for transparency with a sustainable level of effort and administrative costs for the industry.

Regarding UM approval duration, we have several concerns about this proposal as it relates to Part B drugs. First, managing the approval duration is an important tool used to prevent overutilization. This is done both to reduce fraud, waste, and abuse (e.g., duplicate billing under Part B and Part D, etc.) and to protect patients from continuing medications that are ineffective or no longer effective, especially where the drug poses a safety risk for the patient or prevents changing to a new therapy that may be effective.

Second, we are concerned about how the proposed regulatory language, as stated, would impact approvals of maintenance drugs. Unlike many other Medicare basic benefits, Part B drug therapy is often used for prolonged periods of time. The proposed regulatory language, as stated, could be interpreted as requiring *lifetime* approval durations for maintenance drugs. Although a patient's diagnosis may be unlikely to change, the most clinically appropriate and cost-effective alternatives are likely to change as the pharmaceutical landscape changes over time. A periodic PA requirement prompts the

CVSHealth
1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

provider, patient, and plan to reevaluate the drug therapy, consider alternatives, and make changes if warranted.

Last, as previously stated, the proposed rule does not account for times when the planned duration of therapy is unknown during the PA review. This is a particular concern for Part B drugs given the very short timeframes for reviewing PAs for them (24 hours and 72 hours for expedited and standard requests, respectively) and our experience that PA requests for drugs often do not include the planned duration of therapy. When a PA is approved, the parties to the request must be informed of the terms of the approval, including the approval duration. In addition, the plan must log the approval duration in its software system(s) to effectuate the approval. If a plan is required to approve coverage for the full intended duration of use and the plan cannot obtain this information during the applicable PA review timeframe, the plan would have to deny coverage even though the drug is medically necessary and eligible for coverage.

In addition to our general comments regarding the proposed transition requirement for Medicare basic benefits – which we largely support – we have several concerns that are specific to Part B drugs. For example, Part B drugs differ from other basic benefits in that many of them can be covered under *either* Part B or Part D, depending on the circumstance. One such circumstance depends on whether the drug is dispensed by a pharmacy or furnished in another healthcare setting. Drugs are billed through either medical or pharmacy claims adjudication systems depending on where they are furnished. These adjudication systems use different transaction standards and billing codes and therefore do not communicate with each other. The claims are also billed at different points in time. Pharmacies bill *before* dispensing the drug, while other healthcare settings bill *after* the drug has been administered. The post-administration billing can occur months after the date of service. Another issue is that the interoperability rule does not apply to drugs. Therefore, it is unclear whether the planned improvements that will facilitate transition processes for other Medicare basic benefits will improve data sharing around drug therapy. All of this is to say that it will be very challenging for plans and PBMs to determine when a patient is already taking a Part B drug or has received approval for it by their previous health plan.

Unlike other Medicare basic benefits, there is an existing transition process for drug therapy; it just pertains to Part D drugs. It would be cumbersome and confusing to apply very different transition policies to Part B and Part D drugs, especially when a number of those drugs can be covered under either benefit depending on the circumstance. To the extent practicable, we recommend that CMS align transition rules for Part B drugs with those of Part D. This includes needing the ability to make a Part B vs Part D benefit determination when needed before furnishing a transition supply at a pharmacy. Similarly, plans and PBMs will need to know how to proceed when they are unable to determine at point of service whether the patient is already taking (or had already received prior approval from their previous plan for) the requested drug. In the Part D space, plans are required to assume the patient is already taking the drug when they are unable to determine otherwise at the point of service. This process depends on a lookback period to check for previous claims, which

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

due to the lack of interoperability between pharmacy and medical claim adjudication systems noted above, will be very challenging.

In the Part D space, plans are required to apply selected claim edits during the transition period (i.e., safety edits, Part B vs Part D edits, and edits to ensure the drug is being used for medically accepted indication when there is a high likelihood that it is used for a non-Part D eligible purpose). Similarly, we believe UM edits should continue to apply to certain Part B drugs during transition. For example, drugs with significant safety risks (ex. Spravato), those with extremely high cost and limited duration of use (ex. CAR T-cell therapy; gene therapy), those subject to very limited coverage in FFS Medicare (ex. drugs with an NCD covered with evidence development), and those with significant risk of fraud, waste, or abuse. We also ask CMS to consider the implications of providing a transition supply of a Part B drug that is subject to step therapy when the plan is unable to determine whether the patient is currently taking the drug. As CMS explained in the Proposed Rule, step therapy is an important cost management measure for Part B drugs. Under the current rules, plans may only apply step therapy to Part B drugs for new starts or administrations of the drug. Therefore, unless this policy is changed, providing a transition supply of a Part B drug will prevent the application of step therapy.

Recommendations:

- **If CMS retains the Utilization Management Committee requirement, it should allow Part B utilization management to be reviewed by an MA plan's P&T committee, under their current process and without additional requirements or limitations.**
- **CMS should require UM criteria documents to be publicly posted but should not require these documents to contain a detailed summary of each piece of evidence considered or rationale for adopting the policy. Instead, CMS should allow plans to use their current UM criteria format so long as it includes a reference list of the evidence considered in creating the policy. CMS could then wait to see if there is an unmet need on the part of providers, and if so, conduct focus groups with providers to determine the need and work with industry to make the changes. If CMS finalizes the criteria content requirements as proposed, the implementation should be delayed to allow plans time to add the additional content.**
- **CMS should permit P&T committees to determine the appropriate approval durations for Part B drugs. The duration will vary depending on the drug and the circumstance for which it is approved (e.g., the condition being treated, new start vs continuation of therapy, etc.).**
- **CMS should provide additional information, before implementation, of how it expects plans to implement the proposed 90-day transition fill policy. To the extent practicable, CMS should align the transition rules for Part B drugs with those of Part D drugs, including issuing guidance about any UM edits that should still be applied during the transition period.**

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

E. Reviewing Medical Necessity Decisions by a Health Care Professional

CMS proposes to modify the requirement with respect to the expertise of the physician or other appropriate health care professional who must review an organization determination (OD) if the MA organization expects to issue an adverse decision based on the initial review of the request. CMS would add to the existing requirement that the physician or other appropriate health care professional who conducts the review must have expertise in the field of medicine that is appropriate for the item or service being requested before the MA organization or AIP issues an adverse OD.

We understand that this additional requirement continues to allow the MA plan discretion in deciding which physician or other appropriate health care professional with sufficient medical and other expertise is appropriate to issue a determination decision and does not require the MA plan to use a physician or health care professional with the same specialty or subspecialty as the treating physician or other health care provider. We strongly support continued plan discretion.

It would be helpful for plans if CMS explained how it envisions medical necessity review processes to work when there are multiple items and services being reviewed and how CMS intends to review whether a plan's adverse decision reviewer had the appropriate expertise. We also ask CMS to explain how it expects plans to comply with this requirement in the event that the item or service involves a more unusual medical specialty or an item or service. For example, many MA plans may offer dental, vision and hearing benefits as a supplemental benefit; does CMS expect each MA plan to have dentists on call 24/7 for medical necessity review? The same would apply to vision and hearing. Most plans do not have dentists on staff, so if so, we note that this requirement will be costly and CMS should both evaluate the aggregate costs of this proposal across the program and determine whether the benefit outweighs the cost.

Recommendations:

- **CMS should finalize this proposal but should use the term "qualified health professional" to avoid ambiguity and to align with National Committee for Quality Assurance (NCQA) utilization management terminology.**
- **Include language in the CFR and/or final rule clarifying that plans have discretion to determine the appropriate expertise of the health care professional who reviews and denies an OD.**
- **Clarify that pharmacists are generally appropriate reviewers of ODs for Part B drugs and other items routinely dispensed by pharmacies.**

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

F. Gold Carding

CMS "reiterates" in the preamble to this Proposed Rule that it believes the use of gold-carding programs could help alleviate the burden associated with prior authorization and that such programs could facilitate more efficient and timely delivery of health care services to enrollees. Thus, CMS encourages MA plans to adopt gold-carding programs that would allow providers to be exempt from prior authorization and provide more streamlined medical necessity review processes for providers who have demonstrated compliance with plan requirements.

Gold carding purports to streamline medical management, like prior authorization. Although we appreciate that medical management, including prior authorization, can appear burdensome, the burden is justified. Prior authorization, along with other medical management techniques, are used to protect patients, ensure clinical efficacy, and protect both beneficiaries and the Medicare program from unnecessary charges. Gold carding would circumvent prior authorization, leaving plans unable to review items and services for patient safety, prevent adverse drug interactions, and deter controlled substance abuse. Gold carding would also prevent plans from directing patients to the appropriate setting—including the use of network providers and facilities. Patients may be unaware, for example, that their provider has referred them to a facility that is not in the patient's network. Prior authorization flags that, saving the beneficiary from unintentionally incurring higher out-of-pocket costs.

CMS believes that gold-carding is appropriate for certain providers that are more reliable and more consistently adhere to plan requirements, appropriate utilization of items or services, and other evidence-driven criteria. But this misunderstands prior authorization—the vast majority of items and services (over 85%) subject to prior authorization are eventually approved. Rather, prior authorization ensures that the services received are necessary now (rather than after more conservative options), will be received in the appropriate setting (the most efficient and least invasive), and are covered for that particular beneficiary. A prior authorization request may be approved, but in a different setting, or may be approved after the provider clarifies that other less invasive options are not appropriate.

To bypass this safety, quality and coverage check, the provider should have to meet a materially higher standard than currently required to receive prior authorization. This requires a demonstration of substantial expertise; a provider may be a superlative physician, but no single individual can be an expert at every item or service. Accordingly, we believe that any gold card proposal should require demonstrated expertise and a high enough volume of that particular CPT code to demonstrate such expertise. Because we do not believe that there are a sufficient number of providers that meet these criteria, we do not think that the benefits of establishing and maintaining a gold card program would outweigh the costs in plan resources or the risk to the beneficiaries of the receipt of inappropriate items or services.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

We would also note that prescription drug prior authorizations are materially different than medical items and services; any gold card proposal would have to address those distinctions. Prior authorization for drugs may be even more important to ensure patient safety and prevent adverse drug interactions. Plans and their PBMs are well positioned to prevent adverse interactions via real-time review and there is no justification to remove this key safety checkpoint in the name of gold carding when drug prior authorization is generally more streamlined and administratively simple already. In addition, as with medical prior authorization, drug prior authorization plays a case management roll, including by deterring controlled substance abuse (for example, through opioid prescription tracking).

- **Recommendation: CMS should not require the use of gold carding. Gold carding programs are still relatively new across the few states that have implemented these initiatives. We encourage CMS to wait until sufficient data is available from current state programs to conduct an evaluation of any potential strengths or limitations of gold carding.**

G. Timing and Costs

CVS Health recognizes that utilization management in Medicare has been subject to recent criticism and we appreciate CMS' efforts to address the concerns. We believe that utilization management plays an indispensable role in ensuring beneficiaries receive safe, cost-effective, and efficient items and services. It also serves to protect the Medicare program itself from unnecessary and sometimes fraudulent claims. But we share the frustration of many when prior authorization adds delays to treatment and work for providers. We believe that much of these issues can be addressed with ePA and we stand ready to work with CMS and other stakeholders to further streamline necessary utilization management processes.

We are concerned, however, that CMS has not properly considered the costs of its proposals. Each proposal adds administrative and claims costs to plans. In addition, each proposal diverts current resources away from where they are deployed. In short, if CMS chooses to finalize any of its proposals, plans need sufficient time to properly comply. Such compliance may include contracting with additional qualified health professionals, additional actuarial analyses of transition costs, and revising current utilization management roles.

At the same time, as CMS is aware, the currently proposed interoperability rule would impose additional prior authorization requirements, both substantive and procedural. These proposals do not appear to have been harmonized with the utilization management proposals in this Proposed Rule. The interoperability proposal will also create a great deal of work and absorb a great deal of plan resources. However, the interoperability proposal also sets the infrastructure to support the goals of many proposals in this rule. For example, ensuring the 90-day transition in treatment will rely on the payer-to-payer API framework to ensure that a new plan has all the necessary information on a new enrollee's treatment.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

Recommendations:

- **Harmonize the prior authorization requirements with interoperability prior authorization requirements, specifically that any changes CMS proposes should be effective no earlier than the date the interoperability prior authorization requirements are effective (which is currently proposed to be effective for plan year 2026).**
- **CMS should delay enforcement of the utilization management proposals it finalizes in this Proposed Rule until additional guidance is provided by CMS and plans are able to update policies, procedures, organizational structure, and data systems to meet the new requirements.**
- **Evaluate the costs of these proposals to determine whether the benefits are justified by the costs.**

IV. Marketing and Beneficiary Communication (§§422.2262, 422.2263, 422.2264, 422.2267, 422.2272, and 422.2274)

CMS proposes significant marketing and communication changes. We support CMS in targeting deceptive marketing practices and we are committed to partnering with CMS to ensure that beneficiaries receive clear, correct and helpful information about their benefit plan options. CVS Health would urge CMS to balance beneficiary protections with maintaining a convenient and efficient beneficiary experience. We believe that some of CMS' proposals without further clarification or guidance, may have unintended consequences to many stakeholders, including plans, brokers, agents, and, most importantly to the beneficiary.

A. Beneficiary Contact

While CVS Health is supportive of standards to prevent misleading and unwanted beneficiary contact, we note that codifying several of the proposed changes have the potential to drive up wait times for the beneficiary, impacting their experience. We support CMS' proposal to prohibit unsolicited door-to-door contact; however, we seek clarification on the opt-out proposal and have concerns with CMS' proposals requiring time between marketing interactions and beneficiary enrollment.

To eliminate unsolicited contact, CMS proposes that if the MA organization or Part D sponsor reaches out to beneficiaries regarding plan business, the MAO must provide notice to all beneficiaries whom the plan contacts at least once annually, in writing, of the individual's ability to opt out of future calls regarding plan business. We support this requirement to provide beneficiaries with the opportunity to opt-out of communication annually. Aetna currently operates program outreach to existing plan members via outbound call campaigns to explore other Medicare products that may be of interest or serve the beneficiary's needs. We recommend that CMS continue to allow MAOs and Part D sponsors to contact current members with an existing relationship to the plan. These should not be considered "cold calls."

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

We also recommend that CMS not finalize the proposal limiting the time a sales agent can call a potential enrollee to six months following the date that the enrollee first requested information. This timeframe may negatively impact beneficiaries who provides an agent with their contact information and permission to contact, especially at the end of the calendar year. Instead, we recommend that CMS provide a 13-month limitation on this interaction. This would allow a beneficiary to maintain a consistent contact through the start of the following Annual Enrollment Period in the event that they want to switch to a new plan and do not want to initiate a new search. As with any contact, the potential beneficiary would be permitted to opt-out of communication at any time.

CMS' proposal to ban follow up with a beneficiary within 48 hours of the beneficiary initiating interest through the completion of a Scope of Appointment (SOA) form merely forces a beneficiary—who may have been ready to enroll—to find another time to actually complete enrollment. Beneficiaries' time is valuable. This may be particularly important toward the end of the month (or the end of their enrollment period) – a two-day delay in enrollment may lead to a more significant delay in coverage. Many times, a beneficiary may also initiate contact by approaching an agent directly as part of a "walk-in assistance" interaction. In this instance, the beneficiary may not want to complete a SOA and wait an additional 48 hours. In addition, we have consumers that contact us via our website and request a callback at a specified time; that time may be within the next 48 hours and we need to be able to contact them at their preferred time.

If finalized, we recommend that CMS provide beneficiaries with the opportunity to opt out of the 48-hour window if they are ready to engage with a particular agent or plan. This can be communicated to the beneficiary through required language on the SOA, such as "CMS generally requires that a plan broker or agent must wait 48 hours between completing this Scope of Appointment and the actual sales or enrollment meeting. You have the right toto waive this 48-hour waiting period if you are ready to proceed with a sales or enrollment meeting."

Similarly, the prohibition on marketing events within 12 hours of an educational event at the same location may simply discourage brokers and plans from hosting educational events. Educational events are strong sources of information that provide the necessary knowledge to beneficiaries that help them learn about Medicare and their options, this rule is likely to lead to less education. We believe that CMS intends to have all beneficiaries have access to the full range of options available to them; however, limitations on sales following an education event may have a negative impact on access. Rather than setting the time standard, CMS could consider requiring that agents can be in the same building as an educational event but not in the same room, with a clear signage and announcements delineating the educational event from the optional opportunity to interact with agents.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

Recommendations:

- **Finalize the prohibition on unsolicited door-to-door contact without prior appointment**
- **Finalize the requirement for an MAO or Part D sponsor to provide an annual notice to opt-out of communication. CMS should maintain flexibility with the way this notice can be provided through electronic and mailed written communication.**
- **Do not finalize limitations on the ability for a sales agent to call a potential enrollee more than six months following the date that an enrollee first requested information. Instead, we propose a limitation of 13 months following the initial request. This would allow continuity of communication with a beneficiary who contacted a plan at the end of the calendar year, through the start of the following Annual Enrollment Period.**
- **Do not finalize the 12-hour prohibition on marketing and educational events taking place in the same location and the 48-hour ban on enrollment follow-up following the completion of an SOA form. We encourage CMS to instead maintain these as guidelines rather than codifying them as standards, consider reasonable exceptions to these timelines, and/or consider alternative approaches to ensuring the separation between education and marketing interactions.**

B. General Communications Materials and Activity Requirements and General Marketing Requirements

CVS Health appreciates CMS' concern that marketing materials may be misleading, overwhelming, or confusing to beneficiaries. We believe that CMS may be underestimating the value of third-party agent and broker communications in generally educating beneficiaries about their benefit options, without ever mentioning a specific issuer or plan or attempting to "sell" any coverage. Moreover, these agents and brokers may assist beneficiaries with benefits outside of Medicare, such as life or travel insurance, and beneficiaries may seek out reputable third-party agents and brokers based on their brand, customer service and other services. It is preferable for the beneficiary and plans if it is clear that these products and services are not associated with or offered by the MA or Part D plan. We recommend that CMS carefully consider the varied products and services these agents and brokers may offer and not unduly limit or inadvertently prevent agents and brokers from providing these services.

If CMS intends to move forward with these proposals, we will ask CMS to provide more specific guidance through the final rule, the Medicare Communications and Marketing Guidelines (MCMG), and additional subregulatory guidance and examples. For example, plans and brokers need clarification on difference between "marketing," "general communication," and "education." We are concerned with limitations that may be

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

interpreted overly broadly (e.g., use of a Medicaid card as a visual example in educating an enrollee being reported as misuse/misleading).

In addition, CMS should clarify the definition of "plan name," and precisely how an image of a Medicare card may be used. For example, plans may show beneficiaries an image of a Medicare card to determine if the beneficiary may be dually eligible or already have coverage. There are other areas that need clarification; for example, differentiating between what rules apply to Third Party Marketing Organizations (TPMOs), First Tier, Downstream, and Related Entities, and plans themselves. Similarly, CMS would prohibit the use of the Medicare name, CMS logo, or official products, including the Medicare card, in a misleading manner, but the rule does not provide sufficient guidance on what, precisely, CMS means by "misleading." The examples provided by CMS in the preamble are subjective (e.g., "tiny" and "difficult to read"). An alternative to the proposed subjective rule might be to provide a more objective approach such as specifying where the disclaimer must appear on the marketing piece along with font size and type so that it is more prominent and conspicuous. The defined objective rule would provide a safe harbor for plans by rule instead of it being based on personal subjectivity. In short, CVS Health is concerned that while we generally understand CMS' purpose, without clarification, the proposal may be overly restrictive and contribute to more beneficiary confusion rather than targeting and eliminating deceptive practices.

In implementing these new proposals, CMS must also update the MCMG with sample marketing materials and language, including examples that are not compliant. Updated guidance and examples in the MCMG would provide all plans with a clear standard that we can refer to as we exercise oversight over our own marketing material, as well as material created by TPMOs and brokers. It would also be helpful to see how CMS envisions the discloser/disclaimer that must list every sponsor name in marketing materials. Given the number of sponsors and plan names, it would be helpful to see how CMS believes that this disclosure can be made without confusing the beneficiary or swallowing the substantive content. For example, while we can envision how this may work in print according to the proposed font standards, television, online, and social media advertisements may be more difficult to create. An alternative approach could be to require that TPMOs and brokers include an updated page on their website listing the names of all carriers they contract with, organized by the states in which those particular carriers are sold.

Similarly, while CVS Health supports the prohibition on plans advertising benefits that are not available in a service area in a misleading manner, we need clarification on the use of references to benefits in general advertising. Current ads may say "dental, vision" with the clear disclaimer that benefits may vary and the expectation that an agent must walk through the specific benefits available in a given area if the potential enrollee contacts the plan or agent. General ads will be especially tricky in multi-region/state areas where local advertising spans across areas, such as D.C., Maryland and Virginia and requiring specificity in these types of advertisements will be very costly to provide little added value. We urge CMS to ensure that this new proposal would not limit the ability to produce general marketing material.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

One way to enforce this proposal in a balanced manner is to set thresholds for the use of permissible general references to benefits in a given area. For example, if 85 to 100 percent of Aetna's plan offerings in a given area offer a particular benefit such as dental coverage, we state that "most plans offer dental coverage." If 65 to 84 percent of our plans carry the benefit, we state that "many plans offer dental coverage," and if 40 to 64 percent of plans carry the benefit, we say "some plans offer dental coverage" with the additional disclaimer that "not all benefits available in all plans." CMS can utilize similar thresholds to strike a balance on oversight without unintentionally penalizing plans already in compliance.

Recommendations:

- **CMS must update the Medicare Communications and Marketing Guidelines with guidance clarifying the requirements proposed in this section. Updated guidance, along with examples of compliant and non-compliant material would provide all plans with a clear standard that we can refer to as we exercise oversight over our own marketing material, as well as material created by TPMOs and brokers.**
- **CMS should ensure that these proposed requirements do not limit the ability to create general advertisements, especially in multi-state regions where it may be difficult to regulate the range of broadcast advertising. We suggest ways that CMS can enforce thresholds and standards without restricting general marketing.**

C. Required Materials and Content

We support the proposal to require the use of the Pre-Enrollment Checklist (PECL) and standardized checklists to ensure that agents screen for the information necessary to identify the plan that best meets the beneficiary's health care needs. We continue to recommend that these be recognized as guides for scripts/discussions and that each agent must still be able to tailor their conversation to the beneficiary as long as the material in the PECL is discussed.

- **Recommendation: We support the required use of the PECL as a guide to ensure agent scripts and conversations cover essential information with beneficiaries.**

D. Licensing of Marketing Representatives and Confirmation of Marketing Resources

Aetna allocates significant resources to monitoring the TPMOs, agents, and brokers with whom we work. We hold our contracted partners to the same code of conduct that Aetna employees are held to. We strongly support CMS' proposal that MA plans have an oversight plan in place and that plans report agents engaged in non-compliant activity to CMS. We recommend that CMS continue to work with plans to identify the most efficient ways to

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

engage in real-time oversight and reporting. As CMS notes, Aetna, along with many other plans already utilize call recordings, secret shoppers, and other mechanisms to monitor agent and broker compliance.

While Aetna agrees that plans must be responsible for reporting instances of non-compliance to CMS, we are concerned that the expectation to do this in real time may result in overreporting and an increased need for both CMS and the plans to spend time and resources investigating a large number of cases instead of homing in on those agents and brokers that are clearly non-compliant. We thoroughly review every Aetna-related complaint received directly to us or through CMS (e.g., 1-800-MEDICARE or Medicare.gov). In many instances, after reviewing call recordings between an agent and beneficiary, we find that the agent was not deceptive or non-compliant, but instead may benefit from additional training and coaching to improve their communication. While we support the requirement to report non-compliant agent and broker interactions to CMS, we also recommend that CMS still allow plans to perform their own review and performance improvement activity.

Furthermore, to better target plans, brokers, and agents who may be engaged in non-compliant activity, we encourage CMS to work with the industry to set standards on key indicators, such as inappropriate rates of rapid disenrollments. MAOs and CMS should focus greater oversight on those plans who exceed these standards.

Recommendations:

- **Finalize the requirement that MAOs have an oversight plan in place and report non-compliant agent activity to CMS. However, CMS should work with plans to identify ways to monitor compliance in real-time.**
- **CMS should work with the industry to develop key indicators for non-compliance, such as rapid disenrollments linked to a particular agent or broker.**

E. Prohibition on Distributing Personal Beneficiary Data Collected by a TPMO

CMS proposes to address issues with TPMOs distributing beneficiary contact information to multiple entities. CMS believes that when a beneficiary calls a company based on an advertisement, the beneficiary is only expecting to connect with that particular company, not to have return calls made to their personal home or cell number from other companies.

CVS Health appreciates CMS' concern and we agree that beneficiaries should not receive an unreasonable number of marketing inquiries. However, we believe that CMS' proposal is too broad and should not prohibit any distribution of beneficiary data collected by a TPMO. This would limit information provided to a beneficiary to a point where a beneficiary could receive too little information about available plans; a single TPMO, contacted directly by a beneficiary, may not work with all available issuers or have experience with all available

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

plans. Limiting TPMOs from sharing beneficiary leads means that beneficiaries may not receive all the information necessary to make the best coverage decision for them.

To address the issue that CMS has identified, we believe that CMS could propose a limit on how long a TPMO would be permitted to distribute/sell leads to other TPMOs. This would prevent "old" or "stale" information from being shared, helping to ensure that only beneficiaries that are interested in being contacted are contacted. For example, CMS could propose something along these lines: "permission to contact shall expire once the contact is made or nine months after the original date of receipt for MA plan and PDP leads, whichever comes first. If a permission to contact is provided by another TPMO source, the original date of the TPMO shall be used."

Alternatively, or in addition, we believe that it would be reasonable for CMS to limit the number of TPMOs with which the initial, lead-generating TPMO could share the beneficiary information. In other words, CMS could limit the number of times that a lead could be sold.

- **Recommendation: CMS should not prohibit all distribution of beneficiary information collected by a TPMO. Instead, CMS should consider other reasonable limits to protect beneficiaries, including prohibitions on the sharing of "stale" information or limiting the number of times the same beneficiary's information may be shared.**

V. Strengthening Translation and Accessible Format Requirements for Medicare Advantage, Part D, and D-SNP Enrollee Marketing and Communication Materials (§§ 422.2267 and 423.2267)

Current section 422.2267 provides that "all required materials and content" must meet standards specified by CMS. Under the proposal, CMS would now require MA organizations, cost plans, and Part D sponsors to provide all required materials to enrollees in any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package service area or accessible format using auxiliary aids and services upon receiving a request for the materials or otherwise learning of the enrollee's preferred language and/or need for an accessible format using auxiliary aids and services.

CMS also proposes that for D-SNPs, the individualized plans of care for special needs plans must also be provided in the preferred language/method upon receiving a request. Finally, fully integrated dual eligible special needs plans (FIDE SNPs), highly integrated dual eligible special needs plans (HIDE SNPs), and applicable integrated plans (AIPs), translate required materials into any languages required by the Medicare translation standard plus any additional languages required by the Medicaid translation standard as specified through their Medicaid capitated contracts.

CVS Health fully supports CMS' efforts to ensure that Medicare and Medicaid beneficiaries receive accessible information on their benefits. CVS Health offers a number of accommodations to customers, patients, and colleagues in order to make our services

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

accessible to everyone, including individuals with disabilities. We've built strong partnerships with community organizations to ensure we're a proper reflection of the customers and members we serve. Enterprise-wide, we strive to meet and exceed best practices and standards for accessibility and we continue our efforts, every day.

We strongly support the concept of making required member materials accessible to all members but as proposed, we are concerned with both the length of time translation of care plans could take as well as the potentially high costs of translating all required materials on a *standing basis*. While plans currently provide these materials translated on request, plans may not have all of the required materials translated into every possible required language at the ready. These materials are often prepared well in advance of open enrollment for the following plan year and requiring all plans to have all materials translated on a standing basis, whether or not there is a need for such translation by the beneficiary, diverts resources away from other necessary services and may be quite costly for plans.

CMS guidance provides that required communications must be delivered to beneficiaries within a certain timeframe. As a result, plans may still have to send the English version to meet deadlines and then send requested translation or accessibility format. Operationalizing a method for removing this duplication is complex, time-consuming, and costly. For example, the initial setup for Braille accommodation is 20 working days with an additional 10 days for production after plan approval. Beneficiaries who opt-in for audio versions of documents will receive a paper copy first, then an audio version more than five days later. After initial setup, Braille and audio-created beneficiary communications take at least five days (for audio) and seven days (for Braille), and documents cannot be created and maintained to send Braille or audio within three days of the trigger. Not only are these processes time and resource intensive, but they are also costly.

When variable text documents must be translated, the time and resources required, and the resulting costs, increase. For additional context about the complexities involved in complying with this proposal we highlight the following examples:

- **Part D Transition Letters:** These letters must be created and sent within three days of adjudication of a temporary transition fill. The member document is personalized, including name, address, medication, and timing. Although all communications are sent to print within 24 hours of the notice trigger, because of the time required for alternate formats and translations, an initial English copy would still need to be sent first in order to meet the required communication deadline.
- **Coverage Determinations:** These must be sent within 72 hours for standard determinations and 24 hours for expedited requests. These compressed turnaround times include weekends and holidays—times when a translation service may not be available. There is not enough time to complete a translation or alternate format in the timeframe allotted, so an initial English copy would still need to be provided to be compliant.
- **Part D Member Pharmacy Directories:** These must be sent within 3 days of a member request. These are also personalized to include geo-coded pharmacies

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

based on the beneficiaries' exact address. The complexity of collecting this data combined with a need for translation or alternate format is not feasible in 3 days and an initial English copy will need to be provided to meet the delivery timeframe requirements.

- **Medication Therapy Management (MTM) Comprehensive Medication Review (CMR):** Standardized communications must be sent out within 14 calendar days. These documents, averaging around 10 pages each, are highly customized to each beneficiary and therefore take time to properly format and/or translate.

We also appreciate CMS' proposal to have care plans accessible to beneficiaries. However, we think this too will require additional time and resources to implement. As CMS is aware, the care plan may start with a relatively standard framework, but it is quickly customized for the beneficiary. Because of the various parties involved in the care plan design process, it may be difficult for plans to ensure that every part is accessible. For example, if a treatment provider makes notes, it may not be possible for the plan to ensure that those notes are translated or provided in accessible formats such as Braille. Even for items that the plan can translate, we note that care plans often involve complex and technical terms—terms that may not be easily translated immediately.

Additional resources are required when a beneficiary needs both an alternative accessible format and translated materials. CVS Health currently does not have templates in place for all proposed translations in alternate formats and would not be able to provide them on a standing basis without a delay in delivery. This is another example of an occasion that would require us to provide the materials first in English, to meet CMS' deadlines, and then again in the appropriate format/translation. Finally, we note that CMS may not appreciate that these new requirements may require revisions to vendor contracts or contracting with entirely new vendors to ensure that we are able to translate documents on a standing basis. Contracting also adds to the time needed in order to comply with the proposal.

In CMS' estimated impact grid, it states it would cost $10.4 million for plans to provide materials to enrollees on a standing basis. CVS Health's estimation shows that this is grossly underestimated when taking operational updates and maintenance, CVS staffing increases, and IT programming into account.

- For translation alone, to meet current mandated turn-around times per letter without sending an initial English version, CVS Health would need to increase the number of templates exponentially. For example, currently the English language EOB letter type has 135 templates. Increasing the number of templates to accommodate more 30 languages would increase vendor programming by over $23 million each year and translating those templates would cost an additional $4 million annually. We would also need to update current source systems to pull in additional language codes which would cost approximately $2.8 million annually.
- For the accessibility portion of the proposed rule, costs to produce the EOB alone would increase by approximately $3 million annually for Braille versions and $1 million annually for audio versions. Accessibility cost increases are significantly less

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

than translations due to the lower demand for these services, which is why CVS Health is also in favor of expending these resources on more advanced technologies to meet the needs of today's beneficiaries.

- Finally, these work product increases would need be accompanied by approximately 5x the current operational workforce to meet these demands.

CVS Health supports alternate formats to meet beneficiary needs; however, we believe that utilizing currently available technology can result in more beneficial and efficient ways to meet beneficiary needs. For example, we have found that many blind and visually impaired beneficiaries use screen readers as an accessibility aid. In a 2017 study conducted by WebAIM, a nonprofit organization based at the Center for Persons with Disabilities at Utah State University, 75.6% of respondents noted they exclusively rely on screen reader audio and only 4.9% responded they exclusively rely on printed Braille materials.[19]

In short, CVS Health strongly supports accessibility and we already strive to ensure access, every day. We recommend that CMS consider delaying the effective date of these requirements, to ensure that all plans can comply.

Recommendations:

- **Finalize the proposal to provide all required materials in translated and alternative formats but delay the effective date to apply to materials for the 2025 plan year as many materials for the 2024 plan year have already been prepared.**
- **Align translation thresholds at the federal-level rather than setting state-specific standards.**
- **Clarify that plans may provide certain translated materials and accessible formats within a reasonable timeframe after standard materials have been provided; particularly for documents such as care plans that may contain information tailored to the beneficiary.**
- **Permit the use of new technology and other auxiliary aids, such as e-readers/screen readers for the blind and visually impaired rather than Braille. With the availability, expediency, and increased adoption of screen readers, the requirement for Braille printing of documents is duplicative, expensive, and obsolete.**
- **Permit plans to meet this requirement through immediate resources to support beneficiaries, such as translative services, which already exist and work well.**
- **Consider finalizing this requirement for those communications that are most critical for a beneficiary (ANOC, EOC, Formulary, Summary of Benefits) versus requiring all Medicare communications listed in eCFR 422.2267 and 423.2267.**

[19] WebAIM Screen Reader User Survey #7 Results. Institute for Disability Research, Policy, and Practice. https//webaim.org/projects/screenreadersurvey7/.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

VI. Other Medicare Advantage Proposals (§§ 422.111, 422.112, 422.113, 422.116, 422.152, and 422.267)

A. Appointment Wait Time Standards

CMS proposes to codify certain wait time standards from current guidance and to extend those standards to behavioral health services. CMS clarifies that the new minimum appointment wait time standards would be added to the existing requirement that MA organizations establish written policies for the timeliness of access to care and member services so that MA organizations must have appointment wait times that meet or exceed the standards proposed. CMS also solicits comments on alternative specific appointment wait times standards to apply to MA organizations.

CVS Health's goal is to ensure that our members are as healthy as they can be; access to services in a timely manner is critical to that goal. But we must remind CMS that health plans alone cannot solve systemic access issues. Plan standards have to consider the availability of providers in an area. CMS also must be mindful of geographical differences. Different areas have different numbers of providers in any particular specialty and this is true whether the area is categorized as rural or urban. Providers also determine whether they have capacity, and plans must rely upon providers to continue to update their availability. Provider shortages may create wait time challenges that are simply not within the control of plans or even healthcare systems. CMS should consider way of identifying and addressing systemic capacity issues; plans cannot solve this issue.

We are particularly concerned that the proposed wait time standards do not seem typical or particularly realistic, particularly for a Medicare or Medicaid population. There seems to be a disconnect between the actual systemic capacity of health care providers in the United States and the standards CMS has included in the proposed rules. In sum, plans that make good faith efforts to create robust networks and keep their information updated should not be penalized for systemic access problems or other external factors that may impact wait times such as enrollee geography, weather, and provider preference. We urge CMS to revise its expectations to be more realistic and to recognize the limited ability plans have to control wait times.

Recommendations:

- **Maintain wait times as standards in guidance, but do not codify them.**
- **Align wait time standards for behavioral health services with the NCQA standards which are already standardized across provider types.**
- **Consider options to increase the availability of providers and clarify that good faith efforts to create robust networks and keep relevant information updated will not be penalized for systemic access problems.**

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

With respect to particular proposals, we recommend that CMS:

- **Consider an initial period of monitoring to better understand the current state of wait times across primary care, behavioral health, and specialty care. Intentional assessment and evaluation may better inform standardization requirements.**
- **Consider implementing only the primary care time proposal as a pilot. Lessons learned from the primary care pilot may then inform appropriate standards for behavioral health services. By tiering implementation, we believe there will be increased efficiency and quality.**
- **The primary care pilot can also help CMS determine what, if any, compliance thresholds should apply to 90 and 95 percent of appointments.**

In addition, CVS Health asks CMS for clarification on the following items:

- **Is telehealth included in wait time standards? We believe that allowing plans to include telehealth appointments in the numerator and denominator of the measure more accurately reflects actual patient access.**
- **How does CMS propose to account for the variation in availability of certain specialties? We do not believe it is appropriate, or even possible, to measure actual accessibility if CMS does not account for systemic accessibility, national shortages, etc.**
- **How does CMS propose to accommodate member preference in the measurement? For instance, a member may intentionally schedule an appointment over a month in advance to accommodate travel or other schedules. Or they may prefer that particular provider and are willing wait longer to see them than another provider that may be available to them within the prescribed time frame.**
- **How does CMS propose to consider no-shows? Medicaid providers, in particular, may double-book in anticipation of high no-show rates; this may make their availability materially different from a provider that sees a high percentage of established patients and has a very low rate of no-shows.**

B. Behavioral Health Network Adequacy

CMS would add three new behavioral health provider specialty types to the network adequacy evaluation, specify that access to service standards include access to providers that specialize in behavioral health services, and add all the new behavioral health specialty types to the list of the specialty types that that will receive the credit if the MA organization's contracted network of providers includes one or more telehealth providers of that specialty type that provide additional telehealth benefits for covered services.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

CMS also proposes to add behavioral health services to the types of services for which MA organizations must have programs in place to ensure continuity of care and integration of services, including for community-based and emergency services.

As explained above, CVS Health recommends that CMS consider a pilot program for wait times, using primary care. Based on that pilot, CMS could then develop wait time standards for behavioral health. In the alternative, we suggest that CMS clarify that behavioral health wait time standards are just standards and are not requirements. As CMS is aware, the United States does not have a sufficient number of behavioral health providers to meet its need. We encourage CMS to explore other means to increase the number of behavioral health providers available. While CVS Health strongly supports expanded access to behavioral health services, the limited number of providers is exacerbated by the limited number of providers willing to contract with plans that reimburse based on Medicare payment rates. Plans have a limited ability to address these workforce challenges and any CMS proposal related to behavioral health should consider these limits.

CVS Health supports adding the three new behavioral health provider specialty types to the network adequacy evaluation, but we recommend that this provision not be effective before plan year 2025. We also recommend that as additional provider types are added to network adequacy standards, CMS should improve the exceptions process as the density of available providers will always vary by region and there may be limitations as a result. We also support the 10-percentage point credit for behavioral health telehealth providers for network adequacy.

Recommendations:

- **Consider a pilot wait time program (described above) and inform a future behavioral health wait time proposal based on the results of the pilot.**
- **Clarify that any of the standards finalized from this Proposed Rule are standards, not requirements.**
- **Add the three new behavioral health provider specialty types to the network adequacy evaluation, but this addition should be effective no sooner than plan year 2025, especially for prescribers of medications for Opioid Use Disorder (MOUD). Removal of the X-waiver requirement under the Consolidation Appropriations Act of 2023 and other pending regulations will lead to fluctuations in the MOUD provider population between now and 2024.**
- **Improve the exceptions process to address the workforce issues in behavioral health.**
- **Finalize the telehealth behavioral health provider credit for network adequacy.**

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

C. Enrollee Notification Requirements for Medicare Advantage (MA) Provider Contract Terminations

CMS proposes to add additional enrollee notification requirements for provider contract terminations focused on primary care and behavioral health providers. We are concerned that as proposed, CMS' requirements would disrupt current industry standards on beneficiary notification and potentially create more beneficiary confusion.

CMS proposes to require that a termination notice be sent to all enrollees who have ever been patients of these terminating primary care or behavioral health providers (not just current patients). We are concerned that proposal, without a definitive time limit, is overly broad and would require significant staff time and resources. Beneficiaries may be confused perceive their plans as "out of touch" if they are being contacted about a provider they have not seen in years.

CMS also proposes that MAOs notify enrollees at least 45 calendar days before the contract termination for primary care or behavioral health providers. The industry standard for this notification is currently 30 days as there may be providers who terminate their contract with short notice. We recommend that CMS maintain the existing requirement to provide enrollees with notice no less than 30 days after the receipt of a provider's notice of contract termination.

Recommendations:

- **Do not finalize the proposal that a termination notice be sent to all enrollees who have ever been patients of a terminating provider. CMS should work with plans to create a defined cut-off period for those enrollees who should be notified. For example, "notice should be sent to enrollees whose last visit/encounter occurred within X number of years from the date of termination."**
- **CMS should maintain existing standards for plans to notify enrollees of contract termination within 30 days of the plan's receipt of the provider notice. Written notice should be considered sufficient for meeting this requirement.**

D. Health Equity

CMS notes that current regulations require MA organizations to ensure that services are provided in a culturally competent manner and in this proposal, CMS says it is further clarifying the broad application of this requirement to include limited English proficiency, race, culture and ethnicity, disability, LGBTQIA+, individuals in rural areas and individuals adversely affected by persistent poverty or inequality.

CMS proposes to codify two provider directory best practices as regulatorily-required, so that an MA organization would be required to include each provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office in their provider directories.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

In addition, MA organizations would be required to identify which providers offer medications for opioid use disorder. While we support the intent of ensuring that provider directories serve as a resource to help beneficiaries find culturally competent care, we continue to emphasize the challenge of maintaining accurate, up-to-date provider directory information as this is a shared responsibility between providers and health plans.

Recommendations:

- **CVS Health strongly supports broadening the requirement that MAOs provide culturally competent care to all beneficiaries.**
- **We support CMS' proposal to require the inclusion of each provider's cultural and linguistic capabilities in the provider directory. However, we note that MA organizations are limited in the information that they can collect through provider-reported responses.**

E. Digital Health Education for MA Enrollees Using Telehealth

CMS proposes to require MA organizations to have procedures to identify enrollees with low digital health literacy and offer them digital health education to assist with accessing any medically necessary covered benefits that are furnished when the enrollee and the provider are not in the same location using electronic exchange. We agree with CMS that supporting digital health literacy will help improve enrollee access to services through telehealth. We also agree with CMS' assessment that equity in digital health literacy is difficult to attain due to a variety of factors such as but not limited to age, education level, language barriers, and the lack of private space or technology to support a virtual visit. To that end, we would welcome working with CMS to design standard communications that CMS could provide to all beneficiaries; this would ensure that all beneficiaries receive the same, accurate digital literacy support and education.

MA organizations would also be required to provide information about digital health education available on request. While we support the collection of this information, we ask that CMS delay any requirement to collect and provide information to CMS until 2025. This will allow plans to focus first on the development and testing of screening methods that best fit the populations they serve. This will also provide us with additional time to develop an infrastructure for data collection. For example, information about an enrollee's digital health literacy may come up across a variety of interactions, such as a provider visit, a case manager conversation, or even as part of a customer service call.

Additionally, we remind CMS that measuring ongoing engagement with digital health education may be difficult to track. While CVS Health and Aetna already provides several educational resources on our website[20], there may be cases where a referral to a

[20] Joseph, C. *Telemedicine: How to take advantage of this health care perk*. Aetna. https://www.aetna.com/health-guide/what-is-telemedicine.html.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

community organization or partner may be more appropriate to provide the enrollee with targeted education on their specific need. Aetna is currently partnering with local communities on pilots to improve digital health literacy.[21] We encourage CMS to utilize the lessons learned from this activity to build the framework for data collection and measurement efforts.

Recommendations:

- **We support the identification of enrollees with low digital health literacy and offering those enrollees digital health education. CVS Health encourages CMS to develop standard beneficiary materials that can be provided on websites or in written material.**
- **We encourage CMS to maintain flexibility with the requirement to screen beneficiaries for digital health literacy this as there are currently no standardized methods for screening and there may be wide variation in the levels of reported digital health literacy among enrollees.**
- **We recommend that CMS require data collection on enrollee digital health literacy and engagement in educational resources no earlier than 2025. This will allow plans to focus first on the development and testing of screening methods that best fit the needs of the populations they serve.**

F. Quality Improvement Program

CMS proposes to require MA organizations to incorporate one or more activities into their overall quality improvement program that reduce disparities in health and health care among their enrollees.

CVS Health supports CMS' efforts to increase quality and reduce health inequities. CVS Health and Aetna have already implemented several programs to reduce disparities, including staff training to ensure that underserved populations have access to customer service. grievance, and appeals services that are culturally and linguistically appropriate, including required training in conscious inclusion and unconscious bias for all our employees. We further appreciate and strongly support CMS' proposal to allow plans to define appropriate quality improvement activities.

- **Recommendation: We support this proposal. We strongly support plan's ability to define appropriate quality improvement activities that address their member's unique circumstances.**

[21] Community News: *Aetna Medicaid gave $450,000 to support Texas communities.* CVS Health. Sep. 13, 2022. https://www.cvshealth.com/news/community/a-commitment-to-community-aetna-empowers-local-organizations-to.html.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

VII. Shortages of Formulary Drug Products During a Plan Year (§ 423.120)

CMS proposed to codify and expand existing sub-regulatory guidance regarding shortages of formulary drug products during a plan year. Specifically, it proposes to require Part D plans to permit enrollees affected by a shortage to obtain coverage for a therapeutically equivalent drug or an interchangeable biological product, if any, for at least the duration of the shortage without having to obtain an exception or meet any prior authorization or step therapy requirements. CMS states that Part D sponsors would be required to cover a therapeutically equivalent drug or interchangeable biological product as an alternative to the formulary product subject to shortage if there is claim submitted for the alternative.

If this is the case, CVS Health requests CMS to specify any requirements for implementation, including expected timing after the FDA lists a new drug shortage on its website. We also ask for guidance on acceptable approaches that would meet the intent of the requirement. For example, can the coverage for a therapeutically equivalent drug be provided through a process such as call center entry of an override for individual members who are unable to fill the drug in shortage, or is there an expectation or requirement that coverage must be provided at the point-of-sale?

Recommendation:

- **CMS should provide guidance on the implementation of the requirement to cover an alternative formulary product during a drug shortage if a claim is submitted for the alternative. This guidance should include (i) giving plans and their PBMs sufficient time after the FDA lists a new drug shortage on its website to implement this requirement, and (ii) allowing alternative approaches to coverage at point-of-sale, such as allowing a call center to enter an override for individual members who are unable to fill the drug during the shortage.**

VIII. Changes to an Approved Formulary (§§ 423.4, 423.100, 423.104, 423.120, and 423.128)

Currently Part D sponsors may, subject to certain requirements, immediately remove from the formulary a brand name drug and substitute its newly released generic equivalent. CMS proposes to permit Part D sponsors, subject to the same conditions, to immediately substitute: (i) a new interchangeable biological product for its corresponding reference product; (ii) a new unbranded biological product for its corresponding brand name biological product; and (iii) a new authorized generic for its corresponding brand name equivalent.

CVS Health applauds the proposals to expand flexibility to include interchangeable biologics, unbranded biological products and authorized generics. However, CVS Health believes the current requirement to implement a formulary enhancement (i.e., addition of a new product) 'at the same time' as a negative formulary change could potentially

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

undermine the intended benefit. A better member experience, increased industry adoption, and opportunity to reduce costs may result if plans had additional implementation flexibility.

Specifically, plans can expedite implementation of a formulary enhancement (e.g., a new generic or authorized generic) to provide beneficiaries with access to a new lower cost alternative as soon as possible. However, additional time is often required to complete other activities prior to making and implementing decisions regarding the current formulary product. This may include activities such as evaluation of the new product's attributes (e.g., formulation, interchangeability, pricing), confirmation of sufficient availability in the marketplace, communication of changes, and updating of systems. Providing a window of time after addition of the new product to implement a corresponding negative change (instead of requiring that both changes be implemented simultaneously) would support these activities, with the goal of providing a seamless member transition, avoiding potential delays in access to care and a better member and provider experience.

This may be particularly impactful in scenarios where there are multiple interchangeable biologics and it may not be readily apparent to the member, pharmacist, or physician as to the preferred interchangeable product, which may lead to a poor member experience and potentially delayed access to care. This added time would still allow plans to follow their existing best practices for providing retrospective member notifications, including through use of the Explanation of Benefits (EOB). CVS Health requests that adding language to Section 4 of the Calendar Year (CY) 2024 Explanation of Benefits (EOB) model to support these immediate substitution changes, to align with planned edits for the CY24 Notice of Formulary Change letter, as the EOB is used to notify beneficiaries.

Recommendations:

- **For situations where plans are permitted to make immediately formulary substitutions, CMS should allow plans a window of time to remove the current formulary product rather than requiring that the removal occur at the same time as the addition. This flexibility will allow plans to ensure a seamless transition for beneficiaries.**
- **CMS should revise Section 4 of the Calendar Year (CY) 2024 Explanation of Benefits (EOB) model to provide language supporting these immediate substitutions changes**

IX. Standards for Electronic Prescribing (§ 423.160)

CMS proposes to adopt the NCPDP SCRIPT Standard, Version 2022011 as the standard for electronic prescribing transactions, and the NCPDP Real-Time Prescription Benefit Standard, Version 12 as the standard for real-time benefit tools ("RTBTs") to be supported by Part D sponsors. Compliance with both of these standards would be required by January 1, 2025. However, since the new electronic prescribing standard would be effective from the

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

effective date of the final rule and CMS proposes to allow use of the current standard, NCPDP SCRIPT standard version 2017071, until January 1, 2025, this means there would be a transition period from the effective date of a final rule until January 1, 2025, during which both standards would be available for use.

CVS Health supports updating the e-prescribing standard and the adoption of a standard for RTBTs, which will ensure consistency across the industry. In this regard, we recommend that CMS considers requiring that patient- facing RTBTs also use the same NCPDP standard to assure consistent information is received by both beneficiaries and the prescribers, regardless of the channel. To take advantage of the most recent enhancements to the RTBT standard, we also support NCPDP's recommendations to adopt the Real-Time Prescription standard version 13, instead of version 12.

CVS Health also recommends adoption of NCPDP SCRIPT version 2023011, rather than 2022011 as outlined in the proposed rule to allow for the most current version of SCRIPT to be implemented.

While CVS Health appreciates the transition period and January 1, 2025, compliance date, we ask CMS to extend the compliance period by at least 12 months to January 1, 2026 and allow for an 18-month transition period for both standards. This longer implementation period is necessary because many of the same resources will be utilized to implement and test both the new e-prescribing SCRIPT standard and the RTBT standard. In addition, the proposed timeline overlaps with the upcoming changes proposed to the NCPDP Telecommunication Standard upgrade to Version F6 and NCPDP Batch Subrogation updates (CMS-0056-P). There are also several other significant Medicare Part D changes occurring in 2025 due to the Inflation Reduction Act, such as a maximum monthly cost-sharing program, Medicare Part D redesign, and significant updates to the Prescription Drug Event (PDE) file layouts. Many of these changes will impact the RTBT, and the longer time frame will allow sufficient time to validate the new requirements, such as the Maximum Out-of-Pocket (MOOP), reductions in beneficiary cost-sharing due to the new manufacturer discount program, and the ability for the beneficiary to opt into the maximum monthly cost-sharing program, prior to using the new standard to communicate these benefits to the prescriber. Finally, requiring implementation of the new e-prescribing and RTBT standards at the same time as these major changes will stretch available resources to the limit, require multiple processes and system changes at the same time, and increase the risk of errors, which in turn, may cause beneficiary disruption.

Recommendations:

- **Adopt NCPDP Real-Time Prescription Benefit Standard, Version 13, instead of Version 12, and require the same standard for patient facing RTBTs.**
- **Delay the compliance date until at least January 1, 2026, for implementation of both NCPDP SCRIPT Standard and the NCPDP Real-Time Benefit Standard to allow 24 months for implementation and allow an 18-month transition period.**

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

X. Gross Covered Prescription Drug Costs (§ 423.308)

CMS proposes to revise its regulatory definition of ''gross covered prescription drug costs'' ("GCPDC") to mirror the statute's language and to remove the phrase ''actually paid.'' CMS states that this change is to remove any ambiguity that might arise from the current regulatory definition as it may now also be applicable outside of the reinsurance context as a result of the use of the term GCPDC in the Inflation Reduction Act of 2022 ("IRA") for other purposes. CMS states that since he revised definition would not change the fact that Part D reinsurance is ultimately based on net drug costs or change the final reinsurance payment amount a Part D sponsor receives, the proposed revision would not constitute a change in policy or require a change in operations under Part D and would not result in government savings or costs.

CVS Health has concerns with the proposed revision and, contrary to CMS' conclusion, believes it will have a major negative impact on the Part D program and government costs. While the current regulatory definition is relevant only to the calculation of reinsurance costs, as CMS indicates, under the IRA the definition will be used to determine "negotiation-eligible" drugs under the Medicare Drug Price Negotiation Program ("Program"). By revising the definition of GCPDC to exclude all direct and indirect remuneration ("DIR"), including manufacturer rebates received after point-of-sale ("POS"), the proposed definition will disincentivize manufacturers from providing such rebates. Instead, single-source drug manufacturers will focus solely on the negotiated price of their drugs, with the result that Part D sponsors and their PBMS will have dramatically reduced leverage to negotiate rebates with those manufacturers and Part D drug costs will increase, in some cases dramatically. We do not believe that this is consistent with Congressional intent, nor do we believe that CMS is compelled to this conclusion by the definition of GCPDC in the statute.

Section 1860D-15(b)(3) of the Social Security Act ("Act") defines GCPDC as "the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year and costs relating to the deductible. Such costs shall be determined whether they are paid by the individual or under the plan, regardless of whether the coverage under the plan exceeds basic prescription drug coverage." There is no reference to manufacturer discounts or rebates in this definition or to the term "actually paid."

While the term "actually paid" is used in the definition of "allowable reinsurance costs" in Section 1860D-15(b)(2) to make clear that such costs must be calculated after considering all "discounts, chargebacks and average percentage rebates," it does not necessarily follow that GCPDC must be calculated before manufacturer discounts are taken into account. On the contrary, the reason allowable reinsurance costs are a subset of GCPDC has nothing to do with manufacturer rebates, but simply because allowable reinsurance costs are limited to costs (1) incurred by the plan alone, not the enrollee, and (2) for basic prescription drug coverage only. This is precisely how CMS described the distinction in the preamble to the 2005 rule, stating (emphasis added):

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

Since allowable reinsurance costs (the subset of gross covered drug costs that are attributable to basic coverage only and are actually paid by the sponsor or plan) can only be fully known after all costs have been incurred for the payment year, we proposed to make payments on an incurred basis to assist PDP sponsors and MA organizations with cash flow.[22]

Any other interpretation would have the anomalous result of determining negotiation-eligible drugs not on the basis of the actual cost to the Part D program of such drugs, but rather, on whether manufacturer discounts, if any, are passed through at POS or after POS. This would give manufacturers considerable control over GDPDC based not on their actual charges, but simply on when they provide their discounts, thus opening up the Program to manipulation and gaming. It is not conceivable that Congress could have intended that if single-source Drugs A and B cost $1200 and $1000 respectively before rebates, but $700 and $1000 respectively after rebates, that Drug A would be considered a higher-cost drug than Drug B and so more likely to be negotiation-eligible.

- **Recommendation: Consistent with the statutory language and Congressional intent, CMS should not change its definition of "gross covered prescription drug costs."**

XII. Part D Proposed Automatic Shipment Requirements (§ 423.505)

CMS proposes to codify its automatic shipment policies consistent with longstanding sub-regulatory guidance. Specifically, among other requirements, CMS states that it proposes to require Part D sponsors to require their network pharmacies to provide a minimum of two shipping reminders to the Part D enrollee prior to shipment, and that sponsors "may specify an approximate shipping date range (for example, 2–3 calendar days) in lieu of an exact date in shipping reminders." However, the proposal then goes on to state that the reminders must include "the scheduled shipping date."

Consistent with CMS's description of its proposal in one section of the preamble, current CMS guidance requires only that the shipping reminder include only a shipping date range in lieu of an exact shipping date. It is not clear whether CMS intends to change this requirement, since it provides no discussion or explanation for the new regulatory text that would require the "scheduled shipping date," and, as mentioned above, there is inconsistent language in the preamble discussion.

Whatever the intent, we ask CMS to consider retaining its policy from the 2020 Final Call Letter that allows a shipping date range, rather than an exact date. This is particularly important because CMS notes it has not received complaints about the current policy. Pharmacies do not have control over the shipment process, and there are many variables that could cause a shipment to arrive a day before or after the anticipated delivery date. Requiring pharmacies to specify an exact date would likely lead to greater beneficiary

[22] 70 Fed. Reg. at 4312.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

anxiety and dissatisfaction, since beneficiaries would have relied on the date specified in the shipping reminder, and there are likely to be occasions when, through no fault of the pharmacy, the actual delivery date is different from that specified in the reminder. A narrow date range is much less likely to lead to such frustration and anxiety and still provides sufficient information for beneficiary planning purposes.

Within the shipment reminder CMS proposes to include, "any applicable cost sharing." CVS Health believes including the applicable cost-sharing in the reminder could lead to confusion if a beneficiary has other medication activity within their plan that causes the benefit level to change between the two reminders. For example, at the time of generating the first or second shipping reminder, it may appear the next mail-order pharmacy claim for a maintenance medication will be covered under the initial coverage limit (ICL). However, a beneficiary might then fill an antibiotic or other acute medication at a retail pharmacy prior to the final processing and shipment of the maintenance medication. This scenario could cause the maintenance medication to be covered partially or fully within the coverage gap, which could impact a beneficiary's cost sharing.

As stated earlier, CVS Health recommends codifying the language finalized within the 2020 Call Letter published on April 1, 2019 in which CMS finalized shipment reminders for cost share to be flexible and plans were permitted to provide information on how to determine cost-sharing of an upcoming shipment, in lieu of the exact cost sharing amount.

- **Recommendation: CMS should codify its current automatic shipment policy, which is working well and for which there have been no complaints and continue to allow shipment reminders to include a date range rather than an exact shipment date and allow information on how to determine cost-sharing in lieu of the exact cost sharing amount.**

XI. Civil Money Penalty Methodology (§§ 422.760 and 423.760)

CMS proposes to revise its "minimum penalty increase policy" with respect to the calculation of civil monetary penalty (CMP) amounts. Among other changes, CMS proposes to eliminate the policy finalized in the Contract Year (CY) 2022 rule to update the minimum CMP penalty amounts no more often than every three years. CMS also proposes to remove the annual cost-of-living multiplier. CMS states that in hindsight "other parts of the regulations" unnecessarily complicated CMS's approach to calculating CMPs, which has the effect of limiting CMS's ability to protect beneficiaries when CMS determines that a higher CMP amount than would normally be applied under the CMP methodology is warranted.

The proposals, if finalized, would allow CMS to set the minimum penalty and aggravating factor amounts each year rather than every three years. While CVS Health appreciates the need for CMS to be able to impose higher penalties in some cases to protect beneficiaries, nothing in the current policy prevents that and, as CMS states, it promotes transparency and consistency. It is for this reason that CVS Health welcomed the language providing that CMS would update minimum penalty amounts no more often than every three years,

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

commenting that it would help to ensure that plans in a given audit cycle would be subject to the same penalty amounts. If this language is now removed as proposed, the potential now exists that plans going through a program audit could be subject to different penalty amounts during the same audit cycle, resulting in inconsistencies and disparate treatment. CVS Health recommends that CMS reconsider removing the "minimum penalty increase policy" because this policy helps to ensure parity.

- **Recommendation: In order to ensure transparency, consistency and parity between plans, CMS should retain the regulatory language that provides that minimum penalty amounts will be adjusted no more often than every three years.**

XII. Part D Sponsor Website Requirements (§§ 423.2265(b)(12) and 423.2265(c)(1)(vi))

CMS proposes, consistent with existing policy, to require a Part D sponsor to post its utilization management (UM) criteria, as approved by CMS, be posted on the plan's website by October 15 prior to the plan year. CMS states that plans may continue either to post plan-specific UM criteria within a custom form or to post these separately from the model form.

CVS Health supports this requirement, but since CMS does not always approve all UM criteria before October 15 of the prior plan year, we recommend that CMS require that the UM criteria be posted by October 15 or after CMS provides approval, if later.

- **Recommendation: CMS should specify that UM criteria must be posted on a Part D sponsor's website by the later of October 15 of the preceding year or after CMS approves the criteria.**

XIII. Part D FDR Subcontractors May Terminate Only at the End of a Month (§§423.505)

CMS proposes a provision will require that contract termination between a Part D sponsor and an FDR initiated by the FDR, providing certain functions as denoted, could only occur after a 60-day notice period and have an effective date that coincides with the end of a calendar month. CVS Health understands that the proposal relates to contract termination for said functions as initiated by the FDR and not the plan or PBM's contracts with downstream entities. As an example, CVS Health understands that the proposed rule is not related to situations where a plan or PBM terminates a pharmacy (due to beneficiary risks or contract violations), but only situations when a pharmacy initiates the termination.

- **Recommendation: CVS Health seeks clarification from CMS that the proposed rule is applicable to terminations initiated by the FDRs and not by the plan or PBM's contracts with downstream entities.**

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

XIV. Request for Comment on the Rewards and Incentives Program Regulations for Part C Enrollees (§ 422.134 and Subpart V)

Reward and incentives programs have become an effective way to increase beneficiary engagement in their own care. We appreciate that CMS recognizes that current regulations on the parameters for what is considered a "cash equivalent" may be unclear, especially as gift cards increasingly become a preferred beneficiary reward due to their ability to control the use of the gift card funds.

- **Recommendation: We support CMS providing more specific guidance, especially on the definition of a "cash equivalent," through the Rewards & Incentives regulation so that we can more easily determine which types of rewards are acceptable to CMS.**

TAB 15

PUBLIC SUBMISSION

As of: March 04, 2024
Received: February 13, 2023
Status: Posted
Posted: February 15, 2023
Category: Health Plan or Association - HP010
Tracking No. le3-5y1d-ksdo
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0191
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024

Comment On: CMS-2022-0191-0001
Medicare Program: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, etc.

Document: CMS-2022-0191-0547
Comment on CMS-2022-0191-0001

Submitter Information

Email: GHertel@ahcusa.com
Organization: Alignment Healthcare USA, LLC

General Comment

Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, CMS-4201-P

Attachments

ALHC Comment Letter_MA Part D Rule 2023.0213_FINAL

Alignment Health™

1100 W. Town and Country Road,
Suite 1600
Orange, CA 92868

ALIGNMENTHEALTH.COM

VIA ELECTRONIC SUBMISSION: http://regulations.gov/

February 13, 2023

Chiquita Brooks-LaSure
Administrator, Centers for Medicare and Medicaid Services

Meena Seshamani, MD, Ph.D.
Principal Deputy Administrator and Director
Center of Medicare

Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–4201-P
P.O. Box 8013
Baltimore, MD 21244

Re: Alignment Health Plan Comments on CY 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Program CMS–4201–P

Dear Administrator Brooks-LaSure and Deputy Administrator Seshamani:

On behalf of Alignment Health, we appreciate the opportunity to comment on the proposed rule: 87 FR 79452 released December 27, 2022 by the Centers for Medicare & Medicaid Services (CMS) titled: *"Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications."*

BACKGROUND

Alignment Health is championing a new path in senior care that empowers members to age well and live their most vibrant lives. Alignment Health is a tech-enabled Medicare Advantage company that serves approximately 108,000 members in 52 counties across six states. The company partners with nationally recognized and trusted local providers to deliver coordinated care. Every member also benefits from Alignment Health's customized care model, powered by its 24/7 concierge care team and purpose-built technology, AVA®. Alignment's mission-focused team makes high-quality, low-cost care a reality for members every day. As we scale our high-quality plans nationwide, Alignment Health upholds its core values of leading with a serving heart and putting the senior first and honoring the voice of the patient.

Alignment Health has dealt with unique challenges with having ten H-contracts ranging in membership from 47 to 77,589 in multiple markets, with the delegated provider healthcare model in California, and with the lingering impacts of the COVID Public Health Emergency, we are proud of our strong Medicare Advantage Star Ratings. Alignment achieved 5 out of 5 stars for its North Carolina HMO plan and an overall 4 stars for its HMO in California in 2023, marking the sixth consecutive year the plan has earned 4 stars or more in California. Alignment Health is also rated 5-star for Part D, as well as rated 5-star in CAHPS "Rating of Health Plan" 2018-2022 which demonstrates our commitment to providing consistent well-coordinated care to our members, to the Centers for Medicare and Medicaid Services (CMS) and the Stars Program evolving goals.

ALIGNMENT HEALTH COMMENTS ON SELECTED PROVISIONS

III. Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

P. Medicare Advantage (MA) and Part D Marketing (Subpart V of Parts 422 and 423)

CMS proposes changes related to MA and Part D marketing and advertising rules. We support CMS' proposals to help better educate Medicare beneficiaries about the choices in coverage and protect them from misleading advertising and marketing practices. **We are concerned, however, that more time for implementation is necessary due to the need for more guidance from CMS and potential expanded training for downstream entities well in advance of the fall 2023 Annual Enrollment Period (AEP).** We would like to seek clarification and offer comments on the following provisions:

- CMS proposes to prohibit plans from advertising benefits not available in a service area, unless doing so is unavoidable in a local market.
  We seek clarification from CMS on the definition of "unavoidable." We believe "unavoidable" may be open to interpretation by each organization.

- CMS proposes to require plans to provide an opportunity for a beneficiary to opt-out from contact regarding plan business at least annually in writing. CMS solicits comment on

whether CMS should expand notice requirements to ensure that Medicare beneficiaries are not marketed by MA and Part D plans in a way that is similar enough to cold calling that it should be prohibited.
We recommend this be one-time, upon enrollment and beneficiaries could opt-out by calling in at any time. By requiring plans to send out an annual letter asking for beneficiary preference creates added burden and confusion for beneficiaries.

R. Part D Medication Therapy Management (MTM) Program (§ 423.153(d))

We support the MTM program goals to reduce medication errors and optimize therapeutic outcomes for beneficiaries with multiple chronic conditions who are taking multiple Part D drugs. Alignment Health believes that the most effective approach is to target MTM program eligibility based on the value of the MTM services to the member, favoring quality of health outcomes over quantity of eligible members. We remain committed to making MTM services available to enrollees with complex drug regimens who would benefit most from MTM services. **Accordingly, Alignment Health has serious concerns with the expanded eligibility criteria for the MTM program as constructed and recommends CMS withdraw the proposed targeting criteria requirements for the reasons outlined below:**

- It will be duplicative of numerous clinical programs and drug management programs in place that target comprehensive disease state, medication drug reviews, and medication adherence management. There are several CMS Part C and Part D Star and HEDIS measures in place today to monitor and measure outcomes for many of the same chronic conditions, including but not limited to:
    - D08: Medication Adherence for Diabetes Medication
    - D09: Medication Adherence for Hypertension (RAS antagonists)
    - D10: Medication Adherence for Cholesterol
    - D12: Statin Use in Patients with Diabetes (SUPD)
    - C06: Care for Older Adults – Medication Review
    - C09: Diabetes Care – Eye Exam
    - C10: Diabetes Care – Kidney Disease Monitoring
    - C11: Diabetes Care – Blood Sugar Controlled
    - C12: Controlling Blood Pressure
    - C13: Reducing the Risk of Falling
    - C08: Osteoporosis Management in Women who had a Fracture
    - C15: Medication Reconciliation Post-Discharge
    - C16: Statin Therapy for Patients with Cardiovascular Disease

- As such, there will be significant overlap between the populations in these programs/measures and those that meet the expanded MTM program eligibility criteria, resulting in substantial additional costs to the MTM program without necessarily supporting value-based outcomes. Additionally, the expanded eligibility criteria will make it difficult to continue to prioritize members with complex disease states, such as respiratory

disease and mental health, that do not currently receive as much focus but can significantly benefit from interventions to address gaps in care.

- In addition, it will create extensive administrative strain and operational challenges for health plans and providers alike. We expect that most health plans will not have the staffing to support the aggressive increase in MTM volume and are concerned that there is not enough supply of qualified pharmacists and MTM vendors/contractors to meet the high demand that will be created. The focus of the MTM program will shift from quality to quantity, reducing the amount of time pharmacists are able to dedicate to member interviews, as well as the comprehensiveness of medication reviews, in order to keep up with the volume demand to maintain the Part D Star rating for the MTM Program Completion Rate for CMR. We recommend CMS retire this Star rating measure and make it into a display measure or modify it to shift the focus from the quantity to the quality of calls made.

- The high touch requirements under the expanded MTM program may result in increased member abrasion and drive members to request to be put on a Do Not Contact list, preventing other types of program participation and meaningful outreach conducted by the plan. Similarly, there will be an increase in provider abrasion as provider offices will receive an exponential increase in recommendations related to Targeted Medication Reviews that may detract from their ability to effectively address gaps for patients most in need of therapeutic interventions identified through the MTM program. Increased member and provider abrasion and engagement will detract from the larger overall goals of these MTM programs, to the detriment of health outcomes.

We urge CMS to withdraw the proposed targeting criteria requirements under the MTM program. Instead, we recommend CMS continue to offer Part D sponsors the flexibility to manage the MTM program criteria to bring MTM services to the proportion of members that would most benefit from the program, allowing the focus to remain on the quality of health outcomes rather than the quantity of eligible members enrolled in the program.

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System

D. Adding, Updating, and Removing Measures (§§ 422.164 and 423.184)

CMS proposes the following Part C and Part D measure specific changes:

- Adds the Part D Concurrent Use of Opioids and Benzodiazepines measure to 2026 Star Ratings.
- Adds the Part D Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults measure to 2026 Star Ratings.
- Adds the Part D Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults measure to 2026 Star Ratings.

We urge CMS to withdraw adding these measures to the 2026 Star Rating system or, at a minimum, to delay their implementation. These measures pose similar challenges as the High-Risk Medication (HRM) measure and the Drug-Drug Interactions (DDI) measure that CMS previously retired. Moving these three measures to a Star Rating will cause delays in beneficiaries getting access to needed prescriptions, and result in unnecessary disruptions in therapy as the majority of members meeting the measure criteria will be on an established therapy that was deemed clinically appropriate by prescribers. It will lead to implementation of tighter utilization management and safety edits, placing additional burden on prescribers, pharmacists, and beneficiaries without necessarily changing overall drug utilization rates. Though plan coverage limitations may superficially lower PDEs, ultimately, they are not able to prevent beneficiaries from proceeding to fill prescriptions by paying out of pocket.

Moving these three measures to Star Ratings will also place increased administrative burden on the healthcare system. It will result in additional work for pharmacists, prescribers, and Part D sponsors related to prior authorization reviews, increase requests to prescribers, and increase case management volume. This will also negatively impact member satisfaction with the prescription drug benefit and result in increased grievances and lower CAHPS scores. We are concerned that behaviors related to these measures will be difficult to influence beyond what is currently done without causing member/prescriber abrasion.

Specific comments on the Concurrent Use of Opioids and Benzodiazepines Measure:

- Duplicative of Medicare Part D required Drug Management Programs (DMPs) and Overutilization Monitoring System (OMS) reporting for beneficiaries who are at risk for misuse or abuse of frequently abused drugs. Part D sponsors are regularly engaged in the case management of Potential At-Risk Beneficiaries (PARBs) reported through OMS. In addition, sponsors also proactively identifying PARBs through DMPs and report any sponsor-identified PARBs through OMS.

- Duplicative of concurrent drug utilization review (cDUR) systems and point-of-sale safety edits, outlined below, that help prevent and address prescription opioid overuse.
    i. Care coordination edit at 90 morphine milligram equivalents (MME) per day
    ii. Hard edit at 200 MME per day or more
    iii. Hard edit for 7-day supply limit for initial opioid fills (opioid naïve),
    iv. Soft edit for concurrent opioid and benzodiazepine use
    v. Soft edit for duplicative long-acting (LA) opioid therapy
    vi. Morphine milligram equivalent (MME) hard edit

  These safety edits help fulfill cDUR requirements outlined in 42 CFR § 423.153(c)(2) and prompt prescribers and pharmacists to conduct additional safety reviews to determine if the enrollee's drug use is appropriate and medically necessary. As part of industry standard, there is also widespread adoption of additional safety alerts at the time of dispensing to proactively engage both patients and prescribers about opioid overdose risk and prevention.

- Duplicative of MTM Programs. The MTM program is designed to assure that covered Part D drugs are appropriately used to optimize therapeutic outcomes and to reduce the risk of adverse events, including adverse drug interactions. Overlap between 1) the populations that meet the MTM program eligibility criteria and 2) an at-risk beneficiary (ARB) that must be targeted for enrollment in MTM, ensures that beneficiaries on frequently abused drugs, such as opioids/benzos, receive a comprehensive medication review along with targeted medication recommendations. Therefore, we believe the MTM program currently addresses the appropriate use of opioids and benzos.

For the reasons outlined above, we urge CMS to withdraw or delay adding these measures to the 2026 Star Rating system.

K. Calculation of Star Ratings (§§ 422.166(a)(2)(i) and 423.186(a)(2)(i))

CMS proposes to make a "technical amendment" to fix a "codification error" in 42 C.F.R. §§422.166(a)(2)(i) and 423.186(a)(2)(i) through the notice and comment rulemaking process under Section 553 of the Administrative Procedure Act ("APA") (5 U.S.C. §553). By doing so in the MA-PD Proposed Rule, CMS is acknowledging that the "technical amendment", i.e., the addition of regulatory language that was inadvertently removed from a regulation that had previously gone through the notice and comment rulemaking process, is in fact an ***amendment to the regulation*** that ***must go through the notice and comment rulemaking process***.

Pursuant to 5 U.S.C. §551(5), an agency must use the same procedures when they amend or repeal a rule as they used to issue the rule. *See e.g.*, *Perez v. Mortgage Bankers Ass'n*, 575 U.S. 92, 101 (2015). Although CMS has stated that the language at issue was inadvertently removed from the regulation, and that its intent to implement the Tukey outer fence outlier policy for the 2024 Star Ratings (i.e., the Star Ratings issued in October 2023) has not changed between the time the policy was initially codified in the regulation (June 2020) and when the language was removed from the regulation (May 2022), the practical effect of adding this language back into the regulation at this time is to impose a ***substantive change*** to the agency's policy ***as it is currently stated in the regulation***. *See e.g.*, *Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87 (1995). Specifically, anyone looking at the regulatory language in 42 C.F.R. §§422.166(a)(2)(i) and 423.186(a)(2)(i) published in the current online version of the Code of Federal Regulations, the e-CFR (Electronic Code of Federal Regulations) that was last amended on February 1, 2023,[1] would find no mention of the implementation of the Tukey outer fence outlier policy under the regulations related to the "Calculation of Star Ratings" for the MA and Part D programs.

Further, while preamble language can be useful in interpreting the regulation, it does not itself qualify for judicial deference. *See e.g.*, *United States v. Mead Corp.*, 533 U.S. 218 (2001).

[1] The last update to Title 42 of the Code of Federal Regulations in the Annual Edition of the Code of Federal Regulations was made in October 2021. On the Code of Federal Regulations website (available at www.govinfo.gov), there is a link directing the public to "Click here to access the e-CFR (Electronic Code of Federal Regulations), the regularly updated online version of the CFR."

Currently, the preamble language from the June 2020 and May 2022 MA-PD Final Rules does not reflect what is actually stated in the current version of the regulation and therefore cannot be relied upon to justify merely making a "technical amendment" to the regulations in order to implement the Tukey outer fence outlier policy as originally proposed in 2020.

Accordingly, by CMS' own admission, CMS cannot simply re-instate language that was removed from the regulation without going through the notice and comment rulemaking process. And by doing so, the APA requires CMS to provide the public with notice and an opportunity to comment on the implementation of the policy itself (i.e., the application of the Tukey outer fence outlier policy for the 2024 Star Ratings). Furthermore, CMS must give real consideration to the comments submitted with respect to the re-addition of the Tukey outer fence outlier policy to the regulation at this time, and not just to comments that speak solely to CMS' act of re-instating language that was removed from the regulation. Specifically, there is actual performance data available now, which was not available at the time the policy was initially codified in the regulation, that CMS needs to consider before implementing the Tukey outer fence outlier policy for the 2024 Star Ratings. This data, as described below, shows a substantially significant shift away from what CMS stated the impact of the policy would be back in 2020, and therefore requires adequate consideration by the agency now before merely re-instating the language that was removed from the regulation. Such data, which is fundamental to assessing the impact of the policy, was not, and could not have been, known at the time the policy was initially adopted in 2020 because it was not available at that time.

Now that the data is available, as part of the rulemaking process, CMS must prepare a new Regulatory Impact Analysis (as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), Executive Order 13272 on Proper Consideration of Small Entities in Agency Rulemaking (August 13, 2002), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)) that adequately assesses the costs and benefits of the proposal to implement the Tukey outer fence outlier policy. CMS cannot rely on the Regulatory Impact Analysis used in 2020, given that other policies related to the mechanism for calculating the Star Ratings continue to evolve, and the availability of actual performance data to assess the impact of the Tukey outer fence outlier policy on the calculation of the Star Ratings has changed. **CMS must delay the implementation of the regulatory amendment and re-assess the policy before merely finalizing it as originally proposed in 2020.**

Figure 1: Tukey Methodology Timeline

We appreciate CMS' continuous efforts to increase the predictability and stability of Star Rating cut points while making them meaningfully distinguish the true performance. However, there are serious reliability issues along with unintended, unexpected, and uncontrollable consequences of implementing the Tukey methodology for the 2024 Star Ratings. **We strongly urge CMS to delay implementation of the Tukey outer fence outlier policy at least until the 2026 Star Ratings in order to allow for time to mitigate these serious issues prior to implementation.** Implementing the Tukey methodology for the 2024 Star Ratings will cause unexpected, unintended, and uncontrollable impact to MA plans, provider partners and millions of beneficiaries. We outline the main issues below:

Issue 1: ***Based on current data simulations, there will be a significant impact on 3, 4 and 5 Star cut points, which is contrary to the impact previously stated by CMS.***

CMS stated in the April 2019 MA-PD Final Rule and reiterated in both the February 2020 MA-PD Proposed Rule and the June 2020 MA-PD Final Rule, that CMS had conducted simulations of the impact of applying the Tukey methodology. The results of CMS' simulation of the impact of the application of the Tukey methodology are as quoted below:

> *"In general, there tend to be more outliers on the lower end of measure scores. As a result, the **one to two star threshold** often increased in the simulations when outliers were removed compared to the thresholds when outliers were not removed, **while other thresholds were not as impacted**."*

This was repeated multiple times within these rules. Between June 2, 2020, and December 27, 2022, CMS did not provide additional or differing guidance on the simulated impact of the Tukey outer fence outlier policy. Alignment (and anecdotally many other MA plans) trusted and relied on CMS' earlier statements that application of the Tukey methodology would not have much impact beyond the 1 to 2 star cut point thresholds. We only had the opportunity to

measure the real impact of application of the Tukey methodology and other cut-point methodological changes in October 2022 after the 2023 Star Ratings were made publicly available. CMS also released the Tukey simulation cut points for the first time on December 19, 2022 that enabled health plans to validate their calculations and identify any issues with implementing this methodology. Based on these, we observed for at least seven measures (two HEDIS and five Administrative measures), that cut points will be **substantially** impacted beyond just the 1 to 2 star threshold [*Table 1*]. Most of these measures have a weight of 4 and therefore have a very large impact on the overall Star Ratings.

Table 1: Measure Impact

Measure			Actual RY 2023 Released Cut points				Simulated RY 2023 Tukey Cut points (Guardrails applied)				Difference between Actual and Simulation Cut points			
Name	Type	Weight	1 to 2 Stars	2 to 3 Stars	3 to 4 Stars	4 to 5 Stars	1 to 2 Stars	2 to 3 Stars	3 to 4 Stars	4 to 5 Stars	1 to 2 Stars	2 to 3 Stars	3 to 4 Stars	4 to 5 Stars
Call Center – Foreign Language Interpreter and TTY Availability (C28)	Admin	4	36	59	83	94	76	82	89	95	+40	+23	+6	+1
Call Center – Foreign Language Interpreter and TTY Availability (D01)	Admin	4	30	64	80	91	68	81	91	97	+38	+17	+11	+6
Complaints about the Health/Drug Plan (C23/D02)	Admin	4	1.53	0.89	0.5	0.19	0.68	0.43	0.25	0.12	-56%	-52%	-50%	-37%
Plan Makes Timely Decisions about Appeals (C26)	Admin	4	59	75	85	97	89	93	97	100	+30	+18	+12	+3
Reviewing Appeals Decisions (C27)	Admin	4	68	83	91	97	84	90	95	98	+16	+7	+4	+1
Diabetes Care – Blood Sugar Controlled (C11)	HEDIS	3	39	62	75	83	63	72	80	86	+24	+10	+5	+3
Care for Older Adults – Medication Review (C06)	HEDIS	1	43	70	82	93	73	82	91	96	+30	+12	+9	+3

Based on CMS' multiple statements starting in April 2019 that application of the Tukey methodology will impact primarily 1 to 2 star cut point values, and the fact that the simulation cut points were only just recently released on December 19, 2022, Alignment and other MA plans did not anticipate such substantial cut point increases for the 3 to 4 star and 4 to 5 star cut point values in these measures. The higher performance targets were not known in advance of the Measurement Year, which is why the Tukey methodology should not be implemented until the 2026 Star Ratings, so that MA plans have time to implement necessary changes to get prepared for the higher performance targets, before the 2024 Measurement Year begins. There needs to be enough time for collaboration, education, and planning with provider network and vendor partners to address these unexpectedly higher performance targets.

We respectfully request CMS further consider how the inaccurate guidance on the true impact of application of the Tukey methodology, coupled with the lack of available data to assess that impact, have created an undue burden for MA plans to work with their vendors and providers in time for the 2024 Star Ratings. This will have negative implications on members, providers, and the community. Delaying implementation of the Tukey outlier deletion model until the 2026 Star Ratings will allow Alignment and other MA plans sufficient time to modify current provider and vendor contracts and collaboratively develop implementation tactics and strategies.

Issue 2: ***There will be a significant decline in predictability and stability of the cut points even though the intention was to increase the predictability and stability year to year.***

CMS emphasized repeatedly in **both the February 2020 MA-PD Proposed Rule and the June 2020 MA-PD Final Rule**, that CMS was making cut point methodology changes and applying the Tukey methodology to increase the stability and predictability of the non-CAHPS measure cut points:

> *"We propose the use of Tukey outlier deletion, which is a standard statistical methodology for removing outliers,* ***to increase the stability and predictability of the non-CAHPS measure cut points****."*

CMS also implemented the 5% guardrail policy to reduce the fluctuation and instability of the cut points and to improve their year-to-year predictability:

> *"…a guardrail so that the measure-threshold-specific cut points for non-CAHPS measures do not increase or decrease more than the value of the cap from 1 year to the next. Prior to applying mean resampling with hierarchal clustering, Tukey outer fence outliers are removed. The cap is equal to 5 percentage points for measures having a 0 to 100 scale (absolute percentage cap) or 5 percent of the restricted range for measures not having a 0 to 100 scale (restricted range cap)…"*

CMS also said they will apply the 5% guardrail on prior year's simulated data in the first year that the Tukey methodology will be implemented:

> *"In the first year that this would be implemented, the prior year's thresholds would be rerun, including mean resampling and Tukey outer fence deletion so that the guardrails would be applied such that there is consistency between the years."*

When CMS made these statements in the previous rule, it asserted that "***thresholds other than 1 to 2 Star thresholds were not as impacted***" and that its intention was to increase stability and consistency of cut points between the years. However, now that the impact of Covid-19 has largely been mitigated and we have the benefit of actual simulated cut points for the 2023 Star Ratings using the Tukey methodology, it is clear that CMS' proposed reliance on the Tukey methodology will significantly impact cut points across the board for many measures. Based on the recently published simulations, implementation of the Tukey methodology will create major instability in the first year of its implementation as it significantly impacts the 3 to 4 and 4 to 5 Stars thresholds, which does not align with CMS' earlier comments and simulations.

For example, as shown below in Table 2, a contract that achieved an 85 on the *Plan Makes Timely Decisions about Appeals (C26)* measure earned 4 Stars for this measure under the 2023 Star Ratings. If the Tukey methodology is implemented for the 2024 Star Ratings, the 4 Star threshold for this measure is expected to jump to 97 or even higher (potentially 12+ percentage points increase). The same plan that earned 4 Stars on this measure for its 2023 Star Ratings would only get 2 Stars when the Tukey methodology is applied, even if the plan improves its performance on this measure from 85 to 90 (which is the same as the max amount set in the guardrails). Accordingly, even where contracts show significant improvement in performance,

they would see a substantial decline in their Star Ratings on such a highly weighted measure. This would negatively impact the contracts that have committed resources and effort to try to improve, create an unnecessary financial burden on plans and their provider partners, and create confusion with beneficiaries when they evaluate a plan's Star Ratings.

Table 2: 2023 Star Rating Simulation with Tukey for Plan Makes Timely Decisions about Appeals (C26)

Measure Name	Measure Type	Measure Weight	Actual RY2023 Released Cut points				Simulated Tukey Cut Points (Guardrails applied)			
			1 to 2 Stars	2 to 3 Stars	3 to 4 Stars	4 to 5 Stars	1 to 2 Stars	2 to 3 Stars	3 to 4 Stars	4 to 5 Stars
Plan Makes Timely Decisions about Appeals (C26)	Admin	4	59	75	85	97	89	93	97	100

In summary, even though CMS' stated intention for applying guardrails and the Tukey methodology was to increase the predictability of cut points, it would instead create instability and confusion for beneficiaries. **Alignment Health respectfully asks CMS to delay implementation of the Tukey methodology until the 2026 Star Ratings so that plans have enough time to implement necessary processes to achieve these new targets.**

Issue 3: *These changes will have a substantial impact on the 2024 Star Ratings, but due to the timing of CMS' release of simulated results for the 2024 Star Ratings, MA plans had no opportunity to address performance through arrangements with delegated entities.*

MA plans rely on the performance of certain delegated entities and provider partners to serve their enrolled beneficiaries. The plans set contractual obligations, such as Service Level Agreements (SLAs) and yearly goals based on various criteria including Star Rating cut points.

For example, as discussed above, if the Tukey methodology were applied to the 2023 Star Ratings, the measure *Plan Makes Timely Decisions about Appeals (C26)* would show a dramatic increase for the 2 to 3 Star cut point value (18 percentage points), the 3 to 4 Star cut point value (12 percentage points), and the 4 to 5 Star cut point value (3 percentage points increase and perfect "100") between the actual 2023 Star Ratings cut points and the simulated 2023 Tukey cut points.

The simulation for applying the Tukey methodology to the 2023 results for the companion measure *Reviewing Appeals Decisions (C27)* would also show substantial increases for the 2 to 3 Star cut point value (7 percentage points) and the 3 to 4 Star cut point value (4 percentage points). Both of the referenced measures currently are 4x weighted administrative measures (and will continue to have a weight of 4 at least until the 2026 Star Ratings), which has a considerable impact on the overall Star Ratings results.

Many of the areas reflected in the Star Ratings measures depend on delegated entities even when delegated entities are not responsible for a specific function. For example, for *Plan Makes Timely Decisions about Appeals (C26)* measure, time begins on the date the plan, any unit in the

plan, or any delegated entity for the plan (including delegated entities that are not responsible for processing appeals) receives the reconsideration request. Similarly, for *Reviewing Appeals Decisions (C27) measure,* any delegated entity's decision on an appeal request (even if they are not delegated to make the decision) is binding upon the plan. Accordingly, contractual obligations and SLAs are critical parts of delegation oversight and management. This is especially so in heavily delegated markets like California. However, due to CMS' very late release of the Tukey simulation cut points (on December 19, 2022 – which is the end of the measurement period) and the unexpected impact on higher Star cut-points (contradicting CMS' earlier simulations and statements), MA Plans are unable to make any adjustments to their contracts and SLAs on a retrospective basis. From the simulated cut-points, even one appeal could have a huge impact on the overall Star Rating of a contract. Plans had no opportunity to prepare for these higher cut-points prior to the start of the measurement period.

Delaying implementation of the Tukey outer fence outlier policy until the 2026 Star Ratings Cycle would allow Alignment and other MA plans sufficient time to work with delegated entities and develop implementation tactics and strategies to achieve these unexpectedly higher thresholds.

Issue 4: *The Tukey methodology will increase all cut point thresholds significantly and move the thresholds much closer to each other for many highly weighted measures. This would impact the measures' reliability and statistical significance and require adjustment of each measures' minimum denominator criteria.*

CMS currently applies minimum denominator thresholds for each measure to ensure that contracts have ***enough data to reliably and accurately report on their true performance***. The implementation of the Tukey methodology would have a substantial impact on the cut points for many highly weighted measures. That is ***why it is critical to re-evaluate and re-calculate minimum denominator requirements for the continued reliability of these measures*.** This is crucial to prevent an unintended and major negative impact on growing and/or high performing contracts.

Figure 2: 2023 Star Rating Simulation with Tukey

a)

2023 Star Rating Cutpoints	
1 Star	
2 Star	59
3 Star	75
4 Star	85
5 Star	97

# of untimely appeals	Denominator								
	3	5	7	9	11	15	20	25	30
0	100	100	100	100	100	100	100	100	100
1	66.7	80.0	85.7	88.9	90.9	93.3	95.0	96.0	96.7
2	33.3	60.0	71.4	77.8	81.8	86.7	90.0	92.0	93.3
3	0.0	40.0	57.1	66.7	72.7	80.0	85.0	88.0	90.0

b)

2023 Star Rating Cutpoints (\w Tukey)	
1 Star	
2 Star	89
3 Star	93
4 Star	97
5 Star	100

# of untimely appeals	Denominator								
	3	5	7	9	11	15	20	25	30
0	100	100	100	100	100	100	100	100	100
1	66.7	80.0	85.7	88.9	90.9	93.3	95.0	96.0	96.7
2	33.3	60.0	71.4	77.8	81.8	86.7	90.0	92.0	93.3
3	0.0	40.0	57.1	66.7	72.7	80.0	85.0	88.0	90.0

For example, the "*Plan Makes Timely Decisions about Appeals*" measure has a minimum denominator threshold of 11. Any contract that has fewer than 11 appeals is not rated on this measure due to "not having enough data." Figure 2 illustrates the impact of implementing the Tukey methodology on the reliability of this measure. Figure 2a represents the 2023 Star Rating cut points for this measure and Star Ratings under different denominator vs. untimely appeal scenarios. Figure 2b represents the same scenarios using the simulated 2023 Star Rating cut points using the Tukey methodology. As seen in Figure 2a, with the minimum denominator threshold scenario (11), there was a meaningful decrease in Star Ratings with each additional untimely appeal for the 2023 Star Ratings. If a contract had 0 untimely appeals, it achieved 5 Stars. If a contract had 1 untimely appeal, it achieved 4 Stars. If a contract had 2 untimely appeals, it achieved 3 Stars. If a contract had 3 untimely appeals, it achieved 2 Stars.

However, with the new Tukey methodology (Figure 2b), if the minimum denominator stays the same, **a contract having only one untimely appeal would earn only 2 Stars.** This would be **a drastic decrease in performance rating based on the plan missing a deadline on a single appeal that might have been caused by a minor clerical error, typo in entering dates, delegated entity oversight or another minor issue.** This one untimely appeal would **reduce the rating for this 4x-weighted measure from 5 Stars down to 2 Stars and would substantially impact the plan's overall mean and variance scores, including the reward factor.**

Figure 3: 2023 Star Rating Simulation with Tukey

a)

2023 Star Rating Cutpoints	
5 Star	
4.5 Star	59
4 Star	73
3.5 Star	85
3 Star	97

Avg Membership	#CTMs																		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
400	0.21	0.41	0.62	0.82	1.03	1.23	1.44	1.64	1.85	2.05	2.26	2.47	2.67	2.88	3.08	3.29	3.49	3.70	3.90	4.11
800	0.10	0.21	0.31	0.41	0.51	0.62	0.72	0.82	0.92	1.03	1.13	1.23	1.34	1.44	1.54	1.64	1.75	1.85	1.95	2.05
1200	0.07	0.14	0.21	0.27	0.34	0.41	0.48	0.55	0.62	0.68	0.75	0.82	0.89	0.96	1.03	1.10	1.16	1.23	1.30	1.37
1600	0.05	0.10	0.15	0.21	0.26	0.31	0.36	0.41	0.46	0.51	0.57	0.62	0.67	0.72	0.77	0.82	0.87	0.92	0.98	1.03
2000	0.04	0.08	0.12	0.16	0.21	0.25	0.29	0.33	0.37	0.41	0.45	0.49	0.53	0.58	0.62	0.66	0.70	0.74	0.78	0.82

b)

2023 Star Rating Cutpoints (w Tukey)	
5 Star	
4.5 Star	89
4 Star	91
3.5 Star	97
3 Star	100

Avg Membership	#CTMs																		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
400	0.21	0.41	0.62	0.82	1.03	1.23	1.44	1.64	1.85	2.05	2.26	2.47	2.67	2.88	3.08	3.29	3.49	3.70	3.90	4.11
800	0.10	0.21	0.31	0.41	0.51	0.62	0.72	0.82	0.92	1.03	1.13	1.23	1.34	1.44	1.54	1.64	1.75	1.85	1.95	2.05
1200	0.07	0.14	0.21	0.27	0.34	0.41	0.48	0.55	0.62	0.68	0.75	0.82	0.89	0.96	1.03	1.10	1.16	1.23	1.30	1.37
1600	0.05	0.10	0.15	0.21	0.26	0.31	0.36	0.41	0.46	0.51	0.57	0.62	0.67	0.72	0.77	0.82	0.87	0.92	0.98	1.03
2000	0.04	0.08	0.12	0.16	0.21	0.25	0.29	0.33	0.37	0.41	0.45	0.49	0.53	0.58	0.62	0.66	0.70	0.74	0.78	0.82

As another example highlights, CMS requires a minimum denominator threshold of 800 for the "*Complaints about Health/Drug Plan"* measure. Any contract that has less than an average of 800 enrollees is not rated on this measure due to "not having enough data." Figure 3 illustrates the impact on the reliability of this measure that would occur from implementing the Tukey methodology. Figure 3a represents the 2023 Star Rating cut points for this measure and Star Ratings under different denominator vs. number of CTM scenarios. Figure 3b represents the same scenarios using the simulated 2023 Star Rating cut points using the Tukey methodology.

As seen in Figure 3a, with the minimum denominator threshold scenario (average of 800 enrollees), there was meaningful cut point ranges for the 2023 Star Ratings. If a contract with an average of 800 enrollees had 0 or 1 CTMs, it achieved 5 Stars. If the contract had 2 to 4 CTMs, it achieved 4 Stars. If the contract had 5 to 8 CTMs, it achieved 3 Stars. If the contract had 9 to 14 CTMs, it achieved 2 Stars. However, if the Tukey methodology were applied and the minimum denominator stays the same, a contract having 6 CTMs would earn 1 Star (Figure 3b), as opposed to 3 Stars without applying the Tukey methodology. Similar to the "*Plan Makes Timely Decisions about Appeals"* measure, there would be a drastic decrease in where the plan falls on the cut points from having just one additional CTM making cut point ranges less meaningful, and thus, have a substantial negative impact on the contract's overall Star Rating due to decreased reliability of this measure to distinguish true performance for certain denominators.

As illustrated in the above examples, CMS' implementation of the Tukey methodology without a thorough statistical analysis and adjustment of the required minimum thresholds would have significant unintended impact on the overall Star Ratings. Further, as stated in April 2019 MA-PD Final Rule, CMS evaluates measures for retirement when scores are compressed and topped out such that the measure has low reliability. Given that we now have the simulated results for all measures and there are substantial increases in all cut points for many highly-weighted measures, overall reliability of each measure also needs to be thoroughly examined before Tukey implementation.

We appreciate CMS' efforts to ensure the reliability of the measures to accurately reflect the true performance of the contracts. **However, for the reasons outlined above we strongly urge CMS to delay adoption of the Tukey outer fence outlier policy model until the 2026 Star**

Ratings and mitigate the stated issues before implementation.

Thank you for the opportunity to submit comments on the CY 2024 Medicare Advantage and Medicare Prescription Drug Programs proposed rule. Alignment Health appreciates your commitment to these programs and the beneficiaries we serve together in partnership. Please do not hesitate to contact me at DMaroney@ahcusa.com should you have any questions.

Sincerely,

Dawn Maroney
President, Markets & CEO Alignment Health Plan

TAB 16

PUBLIC SUBMISSION

As of: March 04, 2024
Received: February 13, 2023
Status: Posted
Posted: February 17, 2023
Tracking No. le3-brbz-aiaa
Comments Due: February 13, 2023
Submission Type: Web

Docket: CMS-2022-0191
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024

Comment On: CMS-2022-0191-0001
Medicare Program: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, etc.

Document: CMS-2022-0191-0730
Comment on CMS-2022-0191-0001

Submitter Information

Name: Tim Dube
Address:
Washington, DC, 20004
Email: tdube@pcmanet.org
Phone: 2027565700

General Comment

The Pharmaceutical Care Management Association appreciates the opportunity to comment on the U.S. Centers for Medicare & Medicaid Services' proposed rule titled "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications" as published in the Federal Register on December 27, 2022.

Attachments

PCMA comments on CMS-4201 2024 Part C D rule - February 13 2023

Enclosure - Groom Gross Covered Prescription Drug Cost (PCMA comments - February 13 2023)

PCMA

February 13, 2023

Submitted electronically via http://www.regulations.gov

The Honorable Xavier Becerra
HHS Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Ms. Chiquita Brooks-LaSure
CMS Administrator
U.S. Centers for Medicare & Medicaid Services
Attention: CMS–4190–P
P.O. Box 8013
Baltimore, MD 21244–8013

RE: Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications (CMS-4201-P)

Dear Secretary Becerra and Administrator Brooks-LaSure:

The Pharmaceutical Care Management Association (PCMA) appreciates the opportunity to comment on the U.S. Centers for Medicare & Medicaid Services' (CMS) proposed rule titled "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications" (hereafter referred to as proposed rule), as published in the *Federal Register* on December 27, 2022.[1]

PCMA is the national association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans (PDPs) and operate specialty pharmacies for more than 275 million Americans with health coverage through Fortune 500 companies, health insurers, labor unions, Medicare, Medicaid, the Federal Employees Health Benefits Program, and the Exchanges established by the Affordable Care Act (ACA).

In this letter, PCMA provides discussion and recommendations on the following topics:

I. **Proposed Changes to the Regulatory Definition of "Gross Covered Prescription Drug Costs":** CMS should decline to finalize any changes to the definition of "gross covered prescription drug costs" at 42 CFR 423.308.

[1] 87 Fed. Reg. 79452, December 27, 2022.

II. **Implementation of Other Provisions of the IRA Related to Medicare Part D:** CMS should indicate in the final rule that it will administer the pricing of drugs subject to direct negotiation in a manner similar to, and in conjunction with, the new Manufacturer Discount Program set to begin in 2025.

III. **Updating and Incorporating Long-standing Program Guidance into the Code of Federal Regulations:** We offer several recommendations related to proposals offered by CMS. In general, we support the principle of codifying guidance, which is often stored in several places, to improve the efficiency of plan and beneficiary interactions.

IV. **Request for Comment on the Rewards and Incentives Program Regulations for Part C Enrollees:** CMS should identify a path forward to maintain or improve the ability of MA and Part D plan sponsors to offer enrollees cash equivalent rewards and incentives.

V. **Revisions to the Medication Therapy Management (MTM) Program:** CMS should not finalize this proposal. It should instead undertake a stakeholder engagement exercise to determine which aspects of the MTM program are worth going forward. In addition, CMS should provide more flexibility to help plan sponsors reach the thousands of beneficiaries who are already MTM eligible but not yet engaged.

VI. **Revisions to the Medicare Overpayment Provisions of the Affordable Care Act:** CMS should clarify the continued need for an investigation period and further clarify how plans that receive overpayments on capitated rates would calculate and return these amounts.

VII. **Proposals intended to streamline the adoption of electronic health information interchange:** CMS should update the e-PA standard to NCPDP SCRIPT version 2022011, align the standards and requirements for electronic prescribing and related activities across the Part D program and ONC Health IT Certification program, and finalize an F6 compliance date 44 months after the effective date of the final rule, ensuring that stakeholders have sufficient time to develop and test changes before rolling them out.

VIII. **Changes to the Medicare Part C & D Star Ratings program:** We offer several measure-specific and methodology recommendations to improve the accuracy of plan-level calculations.

PCMA

IX. Transitioning away from Public Health Emergency (PHE)-related policies for Coronavirus-19 covered items and services: CMS should align COVID PHE unwinding with plan year 2024 and formally acknowledge the appropriateness of UM for commercial units of the oral antivirals and monoclonal antibodies for the Medicare program.

Thank you for the opportunity to provide these comments. We look forward to working with you on your ongoing efforts to improve the Part D program and implement the Inflation Reduction Act.

Sincerely,

Tim Dube

Tim Dube
Vice President, Regulatory Affairs

Enclosure: Groom Law Group memo

cc: Jonathan Blum
Meena Seshameni, MD
Amy Larrick Chavez-Valdez
Cheri Rice
Kristin Bass
Debjani Mukherjee

PCMA

I. Proposed Changes to the Regulatory Definition of "Gross Covered Prescription Drug Costs"

CMS is proposing to amend its regulatory definition of "gross covered prescription drug costs" (GCPDC) under 42 C.F.R. § 423.308 to remove all references to the term "actually paid" within the definition to "clarify that GCPDC are not net of all [direct and indirect remuneration]."[2] CMS states that the current definition "may have led to ambiguity as to when the [direct and indirect remuneration] would be netted out."[3] CMS further states that "the use of the phrase ['actually paid'] could create ambiguity when GCPDC is referenced outside of the reinsurance context (as it is now by the [Inflation Reduction Act, or IRA])."[4] Importantly, CMS asserts that the proposed change would "have no impact on Part D payment calculations or reporting requirements" and that "no other rules or policies would be affected by this proposed change, including the rules regarding how to account for coverage not provided by the Part D sponsor…."[5] CMS concludes by stating that "[r]emoving the phrase 'actually paid' from the regulatory definition of GCPDC as proposed would eliminate any ambiguity in the regulation text and help to ensure there is a consistent understanding of the meaning of this term for purposes of both the Part D program and the relevant provisions of the IRA."[6]

PCMA disagrees with CMS's assertions that its proposed re-definition of GCPDC will have no impact on the Part D program. Importantly, the proposed re-definition of GCPDC threatens to undermine Part D plan sponsor and manufacturer negotiations for a wide range of Part D drugs —beyond those selected for Maximum Fair Price (MFP) negotiations. We argue below that CMS's proposal to re-define GCPDC so it is not net of all rebates is precluded by the plain statutory text. We recognize that CMS has suggested that this clarification is necessary based on the existing statutory definition. We believe this legal interpretation is unnecessary, and jeopardizes savings to the program. We have attached an independent legal analysis which outlines how the proposed clarification would actually functions in direct opposition to numerous existing canons of statutory interpretation.

***PCMA recommendation*: CMS should decline to finalize any changes to the definition of "gross covered prescription drug costs" at 42 CFR 423.308.**

A. The Proposed Rule Threatens the Market-Based Structure of the Part D Program

In the proposed rule, CMS mis-states the impact of its proposed GCPDC definition on the Part D program overall, and the agency omits any discussion of how its proposed definition

[2] 87 Fed. Reg. at 79612.
[3] *Id.* at 79611.
[4] *Id.*
[5] *Id.* at 79612.
[6] *Id.* at 79613.

would affect negotiations between Part D plans and manufacturers, including omitting any regulatory impact analysis (RIA) of the agency's proposal.

As CMS is aware, the Part D program is a private sector solution to providing prescription drug coverage in an affordable way to seniors and the disabled. Congress chose this approach because other means of providing seniors with affordable access to prescription drugs would have negatively affected employers providing prescription drug coverage. Congress intended for drug plan sponsors to use their “bargaining power” and their existing business relationships to “negotiate discounts” from drug manufacturers and pharmacies and “drive down the cost of prescription drugs” through “competition,” and then pass those savings on to enrollees and the government in the form of lower premiums and thus reduced government subsidies.[7]

Predictably—and as intended by Congress—Part D plan sponsors have long emulated the private market, in which rebates are central. Since the mid-1990s and through the earliest days of Part D, PBMs and manufacturers in both the commercial and Part D contexts have converged around a business model in which manufacturers pay retrospective rebates to PBMs after the product is dispensed to the enrollee, and PBMs pass rebates on to plan sponsors. Plan sponsors under Part D are then required to report the full amount of the rebates (including any portion that may be retained by the PBM pursuant to the contract between the PBM and plan sponsor) to CMS as drug price reductions and pass the savings on to the government and plan enrollees in the form of reduced premiums and increased benefits. Thus, rebates are a key tool that Part D plans use to offer more competitive and affordable plan options to enrollees. Without the price concessions secured by PBMs as rebates pursuant to market competition that are then reported as direct-indirect remuneration (DIR) after the point-of-sale (POS), Part D plans' ability to offer affordable prescription drug coverage is stymied.

CMS's proposed GCPDC re-definition, however, undermines Part D plan sponsors' negotiating leverage by incentivizing manufacturers to target strategies to reduce total plan expenditures on their drugs to receive a lower ranking, without reducing their own revenues. For example, if manufacturers understand that gross, rather than net prices, will determine whether a drug is selected for negotiation under the Inflation Reduction Act (IRA), manufacturers are less likely to agree to rebates with Part D plans as those price concessions will not be accounted for when the federal government selects drugs for negotiation under the IRA. Under the incentives created by the proposed rule, manufacturers may consider negotiating rebates with plan sponsors only if the concessions are passed through at the POS, so that they are reflected in the revised construct of GCPDC. Furthermore, price concessions at the POS may also signal to other market participants

[7] Conference Report, Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 108 Cong. Rec. S15670, S15761-72 (Nov. 24, 2003) (Statement of 21 Sen. Bill Frist), https://www.congress.gov/congressional-record/2003/11/24/senate-section/article/S15670-2.

regarding an acceptable level of discounting, thereby promoting tacit collusion among competing drug manufacturers and undermining market competition.[8] Either way, CMS's proposed GCPDC definition has downstream implications of crippling Part D plans' ability to engage in genuine market negotiations that secure rebates and reduce Part D costs for enrollees. The effect is clearly not limited to drugs selected for negotiation under Section 1193, contrary to CMS's language in the proposed rule.

***PCMA recommendation*: CMS should decline to finalize this rule so as not to upset the market-based mechanisms by which Part D currently works.**

B. CMS Did Not Fulfill Its Obligations Under the Administrative Procedures Act (APA) and Other Laws and Regulations

In part, CMS avoided discussing the policy implications described above because it did not conduct an RIA for its proposed reinterpretation of the GCPDC definition. Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits.[9] Circular A-4 states that:

> A good regulatory analysis should include the following three basic elements: (1) a statement of the need for the proposed action, (2) an examination of alternative approaches, and (3) an evaluation of the benefits and costs—quantitative and qualitative—of the proposed action and the main alternatives identified by the analysis.[10]

Here, CMS did not conduct an RIA for this proposal. It is unclear whether CMS's omission of the policy implications of its proposed policy was a product of failing to conduct an RIA, or *vice versa*, but CMS has not fully assessed this change sufficiently to determine the "benefits and costs" of its proposed action.

Further violating the public trust, the data upon which the public could conduct its own analyses – namely the Medicare Parts B and D drug spending dashboards – have not been updated with program year 2021 expenditures. It is a version of these data that will be used for the initial drug selection process. They are typically released about 12 months after the

[8] Testimonies of Drs. Fiona Scott-Morton and Craig Garthwaite to the House Judiciary Committee, Subcommittee on Regulatory Reform, Commercial and Antitrust Law (Mar. 7, 2019), https://judiciary.house.gov/calendar/eventsingle.aspx?EventID=1976.
[9] *See generally* Executive Order 12866 – Regulatory Planning and Review (September 30, 1993), https://www.archives.gov/files/federal-register/executive-orders/pdf/12866.pdf; Executive Order 13563 – Improving Regulation and Regulatory Review (January 18, 2011), https://obamawhitehouse.archives.gov/the-press-office/2011/01/18/executive-order-13563-improving-regulation-and-regulatory-review.
[10] *See* Circular A-4 (September 17, 2003), https://obamawhitehouse.archives.gov/omb/circulars_a004_a-4/.

close of the program year, but at the time of this filing are not yet available.[11] So, not only has CMS failed to show the effect of its proposed change on the Medicare program, but the public also has not had an adequate opportunity to make fully informed comments about the effects of this change.

***PCMA recommendation*: Before considering any changes to the regulatory definition of GCPDC, CMS should undertake a regulatory impact analysis in consultation with the stakeholder community.**

C. The Proposed GCPDC Re-definition Violates The Non-Interference Clause

The Part D noninterference clause states that "in order to promote competition under [Part D], the Secretary may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors."[12] Yet this is precisely what CMS's proposed re-definition of GCPDC does: it significantly alters the incentive structure for manufacturers to provide rebates to Part D plans by making rebates less attractive to manufacturers concerned about Medicare negotiation under the IRA. In such circumstances, rebates paid by manufacturers will simultaneously represent concessions to the Part D plan on price and increase the likelihood that the drug will be selected for negotiation by Medicare since such price concessions would not be reflected in the drug's "total expenditures" calculation.

While Congress did provide an exception to the noninterference clause to implement the Medicare negotiation program, such amendments do not apply to drugs that are **not** subject to Medicare negotiation.[13] Yet CMS's proposed GCPDC re-definition will have repercussions on drugs regardless of whether they are negotiated by Medicare. In particular, Congress amended section 1860D-11(i)(3) of the Social Security Act (SSA) to clarify that the Secretary "may not institute a price structure for the reimbursement of covered part D drugs, *except as provided under the [Medicare negotiation program]."*[14] In order to require reimbursement at the MFP for a Part D drug, the exception to the noninterference clause for implementation of the Medicare negotiation program was specifically added to paragraph (3), which describes the prohibition against the institution of a price structure for the reimbursement of a covered Part D drug. However, paragraph (1), which prohibits the interference with Part D negotiations between plans and drug manufacturers, was conspicuously not amended. As such, Congress did not intend to undermine the private market model of the Part D program that relies on negotiations between manufacturers and Part D plans, yet this is precisely what CMS's proposed GCPDC re-definition will do. Therefore, CMS's proposed definition violates

[11] The 2020 data were released on January 21, 2022. Had CMS met that timeline for 2021 program data, the public would have had at least a limited opportunity to review these data and be better informed about the drugs most likely to be selected under the proposed rule, and under any alternative definitions.
[12] Social Security Act, § 1860D-11(i)(1).
[13] Section 1198(b)(1)(C) of the Inflation Reduction Act, amending section 1860D-11(i) of the Social Security Act.
[14] *Id*. (Emphasis added).

the noninterference clause, even after considering the amendments made by Congress to section 1860D-11(i)(3) as part of the IRA.

***PCMA recommendation*: CMS should withdraw this proposal since it exceeds its statutory authority. Changes to this definition interfere with the arm's length contract bargaining between manufacturers and PBMs.**

D. Proposed GCPDC Re-Definition Is Precluded by the Statutory Definition of GCPDC

CMS's proposed GCPDC definition is inconsistent with the statutory definition of GCPDC at section 1860D-15(b)(3) because it distorts the meaning of the phrase "*costs incurred by the plan*, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs…." Specifically, in only considering rebates that are passed at the POS, CMS's proposes re-definition of GCPDC ignores other rebates collected by—and therefore costs avoided by—Part D plans.

For example, if a drug has a wholesale acquisition cost (WAC) price of $1,000 but a price net of rebates of $750, the costs "incurred by the plan" are $750, not $1,000. Under CMS's proposed re-definition, however, CMS would treat the $1,000 as the costs "incurred by the plan." This artificially inflates CMS's calculation of the drug costs borne by the Part D plan and fails to acknowledge the private-market structure of the Part D program that relies on Part D plans negotiating rebates on drugs to reduce costs and offer more comprehensive prescription drug benefits to Part D enrollees.

In the proposed rule, CMS points out language in section 1860D-15(b)(2) of the SSA that defines "allowable reinsurance costs" as a "subset" of GCPDC, and the agency notes that section 1860D-15(b)(2), unlike the statutory definition of GCPDC, uses the phrase "actually paid" (net of discounts, chargebacks, and average percentage rebates). As a result, CMS suggests that because section 1860D-15(b)(2) uses the term "actually paid" and is a "subset" of GCPDC, it follows that GCPDC cannot also be costs "actually paid" by the Part D plan.

Although we acknowledge this distinction in the statutory language between the definitions for "allowable reinsurance costs" and GCPDC, CMS's characterization of the distinction ignores the rest of the language in both statutory provisions. Specifically, the "allowable reinsurance costs" *involves a more limited data set that would* ***not*** be in excess of "such costs that would have been paid under the plan were basic prescription drug coverage, or, in the case of a plan providing supplemental prescription drug coverage, if such coverage were standard prescription drug coverage."[15] By contrast, GCPDC are "costs incurred" by the Part D plan "**regardless** of whether the coverage under the plan exceeds basic prescription drug coverage."[16] In other words, contrary to CMS's characterization, GCPDC involves a more

[15] Social Security Act, § 1860D-15(b)(2)(A).
[16] *Id.* at § 1860D-15(b)(3).

expansive data set than "allowable reinsurance costs" not because of how rebates themselves are treated (i.e., whether they are "actually paid" or not), but because "allowable reinsurance costs" are limited *to a specific type of drug coverage* (basic prescription drug coverage or standard prescription drug coverage).

***PCMA recommendation*: CMS's proposed change should not be adopted and contradicts the statutory intent of defining GCPDC.**

E. Proposed GCPDC Definition is Arbitrary and Capricious and Fails to Provide Notice to Stakeholders

CMS's lack of *any* discussion in the proposed rule of how its proposed reinterpretation of GCPDC will affect either (i) negotiations between Part D plans and manufacturers or (ii) Medicare Negotiations under the IRA is arbitrary and capricious and deprives stakeholders of the ability to meaningfully consider the proposal and submit informed comments to the agency.

Under the APA, an agency undergoing notice-and-comment rulemaking cannot fail to consider an important aspect of a selected regulatory approach.[17] The agency's articulation of the basis and ramifications of its proposed policies is critical to ensuring that the notice adequately "apprises interested parties of the issues to be addressed in the rule-making proceeding with sufficient clarity and specificity to allow them to participate in the rulemaking in a meaningful and informed manner."[18] By contrast, notice is not adequate if it is dedicated entirely to describing *only one* of the impacts of the proposed policy.[19] Failing to conduct an RIA means this policy is *prima facie* arbitrary.

As discussed above, CMS not only fails to discuss the full impact of its proposed reinterpretation of the regulatory definition for GCPDC, the agency characterizes its proposed reinterpretation as essentially a harmless technical change without any substantive impact on the status quo: "[t]he proposed change would have no impact on Part D payment calculations or reporting requirements…[m]oreover, no other rules or policies would be affected by this change…."[20] CMS fails to even mention, much less discuss, the consequences of its policy on the selection of drugs for negotiation under the IRA and the impact on Part D program negotiations. While CMS expressly solicits comments on more than 50 different policies in its 298-page rule, any solicitation of comments on the re-definition of GCPDC is notably absent. Based on the proposed rule, many stakeholders may fail to submit comments based on CMS's representation that the proposal is inconsequential.

---

[17] *See Motor Vehicle Mfrs Ass'n v. State Farm Auto Ins. Co*., 463 U.S. 29, 43 (1983) ("an agency rule would be arbitrary and capricious if the agency… entirely failed to consider an important aspect of the problem").
[18] *Am. Md. Ass'n v. United States*, 887 F.2d 760, 767 (7th Cir. 1989).
[19] *MCI Telecomm. Corp. v. FCC*, 57 F.3d 1136 (D.C. Cir. 1995).
[20] 87 Fed. Reg. at 79612.

The APA protects stakeholders from an agency's failure to *publicly* consider an issue prior to enacting binding rules. CMS is assuming that stakeholders are able to identify *unstated* policy implications and to simultaneously define the agency's position on those *unstated* policy implications. This is an inappropriate assumption for an agency to make and violates the APA.[21]

***PCMA recommendation*: CMS should abandon this proposed change because it violates the agency's obligations under the APA.**

F. The Proposed Rule Conflicts with Congress' Intent in Passing the IRA

CMS also fails to discuss how its proposed GCPDC re-definition would impact Medicare Negotiation itself. Under CMS's proposed GCPDC re-definition, for purposes of identifying and ranking Part D negotiation-eligible drugs, the Secretary would disregard rebates and other price concessions not passed through at the POS irrespective of how successful Part D plans are in negotiating pricing for those same drugs. Incongruously, this increases the likelihood that Medicare will negotiate pricing on drugs that are already successfully negotiated by Part D plans. This will lead to higher Part D program spending, including for beneficiaries.

The proposed rule would ignore existing PBM-negotiated savings. CMS does not explain why it believes that Congress would want to disregard rebates that Part D plans are successfully negotiating when identifying negotiation-eligible drugs. Given the limited number of drugs that the Secretary may negotiate each year, it is redundant that the Secretary would negotiate pricing on drugs for which Part D plans are already successfully negotiating rebates by relying on an approximation of gross pricing that does not reflect the true cost to the plans or to Part D program spending. If CMS believes that this proposed rule change "clarifies" the intent of the law, it should also have described what alternative it is clarifying against, such as basing the ranking on net program expenditures, instead.

The proposed rule will lead to an inefficient drug selection process. The proposed GCPDC re-definition will result in different drugs being eligible for negotiation, to the detriment of CMS's goals in saving money for taxpayers and beneficiaries, than under the alternative (based upon net price instead). Accounting for other exclusions in the IRA, PBMs negotiated price concessions exceed 50% for the top-ten drugs likely to be selected under

[21] *Chamber of Commerce of the United States v. SEC*, 370 U.S. App. D.C. 249, 259, 443 F.3d 890, 900 (2006) ("By requiring the 'most critical factual material' used by the agency be subjected to informed comment, the APA provides a procedural device to ensure that agency regulations are tested through exposure to public comment, to afford affected parties an opportunity to present comment and evidence to support their positions, and thereby to enhance the quality of judicial review.")

the proposed rule.[22] Independent estimates validate the savings plans and PBMs are able to generate: the Medicare Trustees and CMS Office of the Actuary (OACT) estimate that manufacturer DIR was $30 billion in 2020, or 20% of total Part D spending.[23] Rather, CMS should aim its crosshairs at negotiation-eligible single source drugs without significant price concessions already on the books.

CMS will not meet its savings goals. When CMS moves on to negotiating prices with manufacturers, it will be bound to pay not more than a "ceiling price" based on the length of time the drug has had a "monopoly" or the average enrollment-weighted net price paid by Part D plans. CMS will find more success where the time-based ceiling price provides them leverage over the PBM-negotiated price, since the time-based price is more independent of market forces. Namely, if CMS negotiates for drugs with significant PBM price concessions, they are relying on manufacturers to offer additional discounts to generate any savings at all. By our analysis, PBMs generated nearly $17 billion in savings for the likely top-ten drugs subject to direct negotiation. To meet the Congressional Budget Office's goals,[24] CMS will need to save an additional $4.8 billion, which is a tall order. Instead, if CMS selected drugs based on the highest net program spending, it would more accurately identify drugs where the time-based ceiling price yields savings over the PBM negotiated price.

CMS will pass these higher costs on to beneficiaries. CMS is also risking the significant savings that PBMs negotiate for beneficiaries by proposing to re-define GCPDC. Manufacturers currently negotiate with Part D plans for formulary coverage and preferred formulary placement, including whether cost sharing takes the form of copayments (typical for preferred drugs) or coinsurance.[25] These negotiations enable plans to meet and exceed the adequate formulary requirements under the law.[26] Many high-spend drugs face direct brand drug competition for preferred formulary placement, which incentivizes manufacturers to offer substantial discounts on these products. Under the rule, CMS would supplant PBM discounts that yield copayments for preferred drugs rather than coinsurance. Even if the discounts are similar, manufacturers may lack an incentive to further negotiate with PBMs for preferred status. Enrollees taking preferred brands today, with copays under $50 for cost

[22] PCMA analysis of the Medicare Part D drug dashboard for program year 2020, using SSR Health price concessions data, and accounting for exclusions from the negotiation-eligible drug list pursuant to Sec. 1193 of the SSA. As noted previously, drugs selected for 2026 will be identified using 2021 program data, and accordingly we made several adjustments to the 2020 data to estimate 2021 program experience.
[23] PCMA analysis of the 2022 Medicare Trustees Report and the 2023 Part C & D proposed rule provision on pharmacy DIR, in order to remove pharmacy price concessions from OACT's total DIR estimate.
[24] See CBO, Estimated Budgetary Effects of H.R.5736, the Inflation Reduction Act of 2022,", at page 7, https://www.cbo.gov/system/files/2022-08/hr5376_IR_Act_8-3-22.pdf. CBO estimates that this provision will generate $4.8 billion in savings for 2026, beyond what PBMs already generate.
[25] In 2022, nearly 100% of MAPD enrollees and 65% of PDP enrollees had copayments for preferred drugs, rather than coinsurance. See Kaiser Family Foundation, https://www.kff.org/medicare/issue-brief/key-facts-about-medicare-part-d-enrollment-and-costs-in-2022/.
[26] 42 C.F.R. § 423.120(b)(2).

sharing, will be facing 25 to 33% coinsurance payments for these same drugs, because CMS has limited the ability of PBMs to negotiate on their behalf.

CMS should strive to create a system that is transparent and lacking loopholes. One reason CMS may think that defining GCPDC to exclude price concessions is correct is to reduce the risk of "gaming" the ranking. However, if CMS is concerned that selecting drugs based on actual net prices paid creates incentives to increase price concessions, then it should remember that the data for selected drugs eligible for MFPs in 2026 is based on 2021 total spending, and for 2027, on 2022 total spending. For 2028, Parts B and D drugs will be selected based upon 2023 data, and for Part D, that means contracts and bids closed before the IRA was enacted. These historical data cannot be "gamed" in any fashion. At worst, CMS is trying to solve a problem for 2029. As we described above, changing the rules now creates a slew of unintended consequences across all negotiations – not just those drugs subject to MFP in 2026 and beyond.

Current federal program experience confirms our concerns. Our concerns regarding reduced leverage in the face of significant government mandated discounts are not just mere speculation. We see in other heavily discounted federal prescription drug programs that additional manufacturer price concessions are miniscule, especially relative to the size of the mandated discount. For instance, in Medicaid, manufacturers lack incentive to offer meaningful supplemental rebates to Medicaid managed care plans beyond those offered to the state to secure coverage under the Medicaid Drug Rebate Program (MDRP). Similarly, there is very limited evidence of any real savings available at "subceiling" prices under the 340B program since manufacturers lack significant incentives to offer steeper discounts.

Indeed, the Medicare Part D program itself illustrates that manufacturers will not offer additional discounts or rebates when plans are required to cover a particular drug. The first threshold of coverage—placement on the formulary—is most critical for manufacturers and can significantly affect a manufacturer's willingness to negotiate on pricing. We see this with the "protected class" coverage mandate. Under this policy, Part D plans must cover on their formulary all or substantially all drugs in six protected classes. While manufacturers can offer additional rebates on drugs in protected classes to improve tiering, all analyses of Part D data have consistently shown manufacturers offer only marginal rebates, at best, for these drugs.[27] CMS needs to consider that the private market forces that work in beneficiaries' favor today are neutered when it comes to selected drugs.

[27] "Report to the Congress: Medicare and the Health Care Delivery System," Medicare Payment and Advisory Committee (June 2020), at 143-44. MedPAC remarks on a study finding that "manufacturers provided rebates on fewer brand-name drugs in the protected classes (13 percent vs. 36 percent of all brand name drugs) and that the rebates they did provide were smaller (14 percent of gross costs vs. 30 percent for all brand-name drugs) (*c.f.* Johnson et al. 2018).

PCMA recommendation: CMS should decline to finalize the proposed change because it would undercut the agency's ability to generate savings for the program and beneficiaries.

G. Congress Ratified the Regulatory Definition of GCPDC When It Enacted The IRA

Congress enacted the IRA fully expecting that it would be implemented using the current GCPDC regulatory definition upon which Part D negotiations have been predicated for nearly two decades. In other words, Congress did not expect that, after enacting the IRA without any substantive amendments to the GCPDC statutory definition at section 1860D-15(b)(3), CMS would invert its longstanding interpretation of GCPDC under the pretext that the agency is adopting a nonconsequential clarification.

CMS's revised interpretation of GCPDC contravenes a longstanding principle of statutory interpretation—the ratification doctrine—that "Congress is presumed to be aware of any administrative or judicial interpretation of a statute and [Congress] adopt[s] that interpretation when it re-enacts a statute without change."[28] The IRA represents one of the most comprehensive statutory schemes in modern history—yet Congress adopted only conforming amendments to section 1860D-15(b)(3) of the SSA.[29] As such, Congress is presumed to have incorporated the existing GCPDC regulatory definition when it enacted the IRA, and it understood that the established regulatory regime would dictate implementation of the IRA absent specific statutory amendments.[30] This is particularly true given that the current GCPDC regulatory definition has persisted since the inception of the Part D program—nearly two decades ago—without change.[31]

PCMA recommendation: CMS should reject the proposed rule because the existing definition was assumed by Congress in enacting this new policy.

[28] *Lorillard v. Pons*, 434 U.S. 575, 580 (1978) (alterations made).
[29] Section 11201(b)(3) of the IRA amended section 1860D-15(b)(3) of the Social Security Act solely to ensure that manufacturer discounts under the new manufacturer discount program of section 1860D-14(g) are factored into GCDPC).
[30] *Lorillard*, 434 U.S. at 580 ("Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the interpretation given to the incorporated law, at least insofar as it affects the new statute."); *see also Bragdon v. Abbott*, 524 U.S. 624, 645 (1998) ("When administrative and judicial interpretations have settled the meaning of an existing statutory provision, repetition of the same language in a new statute indicates, as a general matter, the intent to incorporate its administrative and judicial interpretations as well.").
[31] *United States v. Blavatnik*, 168 F. Supp. 3d 36 (D.D.C. 2016) (holding that the ratification doctrine applied in the case before it particularly since the "consensus [as to the interpretation is] so broad and unquestioned that [the Court] must presume Congress knew of and endorsed it.") (alterations made).

PCMA

H. CMS Has Discretion in Selecting Drugs and Does Not Need to Finalize this Change

In the proposed rule, CMS argues that it is making this change to the definition of GCPDC to conform the regulatory text to the statutory text, considering the IRA provision that describes how CMS will select drugs for negotiation. CMS implies that it must select drugs based on its new conceptualization of "gross." However, had Congress explicitly wanted CMS to select drugs by total payments made to pharmacies by plans and beneficiaries (as the new GCPDC maps to), rather than incurred program costs, Congress had access to a much plainer language way to describe it. Congress had other alternatives to more clearly define an amount approximating gross costs.

For example, Congress could have simply defined "total expenditures," in the case of expenditures with respect to Part D drug selection, to mean "total payments made by plans to participating pharmacies on the basis of negotiated price including dispensing fees." They could have defined "total expenditures" as "based upon the spending amounts published by CMS in their annual Part B and Part D drug spending dashboards," or even as "those costs incurred under a Part D plan before excluding any direct or indirect remuneration from any source." Unlike the term Congress instead chose to reference – GCPDC – there is no ambiguity in these alternatives. By referring CMS to GCPDC instead, as we argue elsewhere, Congress is directing CMS to focus on drugs that represent the highest costs to the program and beneficiaries, since those are the drugs where reinsurance reconciliations occur, and thus accounting for the work that PBMs and Part D plan sponsors already do on CMS's behalf. Even if the agency finds the term GCPDC less than clear (or ambiguous), it is certainly a reasonable interpretation of the statute to look at the existing regulatory definition of the term at the time of enactment as a basis for that meaning.[32]

***PCMA recommendation*: CMS should reject the proposed rule because making this change is premature. It should engage manufacturers and PBMs and beneficiaries to ensure that the "right" criteria are used to define negotiation-eligible drugs.**

I. The Proposed GCPDC Re-Definition Could Introduce Similar Incentives to the Delayed Part D Rebate Rule

CMS's proposed reinterpretation of the definition of GCPDC could inadvertently produce the same outcome as the Health and Human Services (HHS), Office of the Inspector General's

[32] *See Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 158, 133 S. Ct. 817, 826 (2013) ("A court must uphold the Secretary's judgment as long as it is a permissible construction of the statute, even if it differs from how the court would have interpreted the statute in the absence of an agency regulation."). *See also Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512, 114 S. Ct. 2381, 2387 (1994) (observing in a Medicare case that Chevron deference "is all the more warranted when, as here, the regulation concerns 'a complex and highly technical regulatory program,' in which the identification and classification of relevant 'criteria necessarily require significant expertise and entail the exercise of judgment grounded in policy concerns.'" (citations omitted).

(OIG's) rebate rule, which Congress delayed implementation of until 2032, nearly a decade from the IRA's enactment. In that delay, HHS alleged that since "beneficiary out-of-pocket costs are often calculated based on the list price of the drug (i.e. before rebates are paid), beneficiaries pay higher cost sharing than they would if discounts were reflected at the point of sale."[33] HHS's proposed solution at that time was to remove protection for rebates under the discount safe harbor and to "create new safe harbor protection for point-of-sale reductions in price, which will directly reduce beneficiary out-of-pocket spending at the pharmacy counter."[34] HHS added that the intent of the Part D Rebate Rule was "to create incentives for manufacturers to lower their list prices…."[35] The rule, however, would have increased costs to the federal government by $196 billion over ten years.[36] This proposed rule will inject similar incentives to the ones that Congress rejected outright when delaying the HHS OIG rebate rule in two of its most recent legislative enactments.[37] Without this regulatory change, the incentives in place today would remain. If CMS makes this change, they've introduced a new incentive for manufacturers to reduce their likelihood of selection by reducing their products' GCPDC through up-front discounts (rebates at POS or otherwise). That shift in strategy, as it would have under the rebate rule, will increase costs on all parties, and benefit only drug manufacturers by reducing the probability of selection.

***PCMA recommendation*: CMS should not adopt a rule change that contradicts Congressional intent and is known to cause economic harm comparable to the delayed rebate rule.**

J. The Proposed Rule Ignores Evolving Trends Among Part B and Part D Drugs and Unnecessarily Treats Part B and D Drug Spend Differently

CMS's proposed re-definition of GCPDC creates an unlevel playing field between Part D drugs – subject to negotiation for 2026 and 2027 – and Part B drugs – which can be negotiated beginning in 2028. The proposed change yields a methodology for measuring Part D spend that stands in stark contrast to how Part B drug spend will be measured for purposes of selecting negotiation eligible drugs. In sum, CMS's proposed re-definition of GCPDC will unnecessarily advantage manufacturers of Part B drugs by mitigating the risk that they will be selected for negotiation, for two reasons.

At the outset, it bears noting that Part B drugs have a structural advantage in mitigating their selection for Medicare negotiation, because Medicare Advantage (MA) utilization is not

[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] *Id.* at 76721; *see also* "Proposed Safe Harbor Regulation," CMS Office of the Actuary (Aug. 30, 2018), https://aspe.hhs.gov/sites/default/files/private/pdf/260591/OACTProposedSafeHarborRegulationImpacts.pdf.
[37] See Sec. 9006 of the Infrastructure Investment and Jobs Act of 2020 (Public Law 117-59, November 15, 2021) and Section 11301 of the IRA.

accounted for when determining negotiation-eligible Part B drugs.[38] Because MA payments for drugs are made under Part C of title XVIII, MA utilization—and the rebates that MA plans negotiate with manufacturers—are not factored into a Part B drug's Medicare spend. By contrast, section 1192(d)(1)(A) of the IRA provides that "total expenditures" for Part D drugs are determined "under Part D of title XVIII." Medicare Advantage Prescription Drug (MA-PD) plans that offer prescription drug coverage offer such coverage under Part D, and therefore MA-PD plan Part D utilization is included when determining a Part D drug's total expenditures.

As CMS is aware, most new Medicare enrollees with Part B coverage are electing MA-PD plans rather than original Medicare. By 2025, half of Medicare beneficiaries will be enrolled in such plans as opposed to original Medicare.[39] As a result, "total expenditures" under Part B for purposes of Medicare negotiation will be calculated on a dwindling population year-over-year, compared to Part D drug spending. Naturally, this tilts drug selection toward Part D drugs because regardless of a Part B drug's cost, the utilization multiplier will progressively decline over the years based on current projections. Ideally, CMS would base drug selection on per-beneficiary spend, or account for Part C spending on Part B drugs, though we recognize these options would require a legislative change.

Moreover, CMS's proposed GCPDC re-definition undermines the current similarity in methodologies for calculating Parts B and D drug spending. Part B "total expenditures" will be based on Average Sales Price (ASP) payments to providers "under Part B".[40] ASP represents the sum of all sales, minus most non-government discounts, across a wide class of purchasers lagged over a 12-month period to account for annual contracts.[41] These discounts include volume-based rebates to physician and hospital purchasers, and price concessions to plans in exchange for favorable treatment on commercial formularies—the latter being virtually identical to DIR under the current definition of GCPDC. Importantly, the ASP methodology focuses on what the *government* pays for a Part B drug, and it aligns with the current GCPDC definition that similarly focuses on what the *government* ultimately pays for a Part D drug. The proposed GCPDC definition would invert this relationship by continuing to count Part B drug spend based on government spending via ASP payments, but only counting Part D *plan* spending rather than what the *government* actually pays for a Part D drug, net of price concessions.

***PCMA recommendation*: CMS should decline to finalize this proposal because it disadvantages Part D drugs compared to Part B drugs in terms of likelihood of selection for negotiation.**

[38] Per section 1192(d)(2)(B) of the Act, Part B "total expenditures" are determined under "Part B of title XVIII".
[39] "Medicare Advantage: A Policy Primer", The Commonwealth Fund (May 3, 2022), https://www.commonwealthfund.org/publications/explainer/2022/may/medicare-advantage-policy-primer.
[40] *See generally* Social Security Act § 1847A and 42 CFR 414.
[41] *Id.* at §§ 1847A(c)(3), 1847A(c)(5)(A).

II. Implementation of Other Provisions of the IRA Related to Medicare Part D

In the previous section, we discussed our concerns with one of just two provisions in the proposed rule related to implementation of the IRA. CMS makes one further proposal, related to new eligibility criteria for the Low-Income Subsidy (LIS) program. We also wish to highlight areas where CMS should consider future rulemaking or guidance to shore up the financial guardrails that protect Part D plans and beneficiaries from high and rising prices for prescription drugs. We close this section by reminding CMS that PBMs can play a critical role in the actual administration of the direct negotiation program, for Part D covered drugs, and should be involved early on as CMS thinks through the operational considerations.

A. CMS Will Increase LIS Eligibility to 150% of the Federal Poverty Limit (FPL)

In line with the requirements of the IRA, CMS proposes to increase eligibility for the full LIS subsidy to individuals with incomes at or below 150% of the FPL. PCMA believes that streamlining the LIS eligibility and enrollment process will improve access for the few hundred thousand beneficiaries currently eligible only for partial LIS subsidies. It will also simplify the administration of the Part D program for plans and pharmacies, with a more unified benefit–either LIS or not LIS–rather than the several "middle grounds" plans must accommodate under current applicable law.

Based on initial analyses by our member companies, we anticipate that plans with higher proportions of LIS beneficiaries will see an oversized premium impact in the shift to the new benefit structure. This could create churn and a disproportionate impact to LIS beneficiaries if there are not steps taken to moderate it. CMS should take steps to make the transition for current LIS enrollees, and future ones, as seamless as possible. With all the changes coming to the Part D program beginning in 2023, there's a high likelihood that the national average monthly bid amount (NAMBA) that the LIS benchmark is based upon could rise substantially, or fluctuate significantly, for 2024, 2025, and 2026. Beneficiaries prefer to remain in their existing plans, but LIS enrollees who do not initially select their plans are at risk of being automatically reassigned if their current plan experiences significant variations over the next few plan years. We believe CMS has the authority to make two changes outlined below in plan offering guidance that it should signal in the final rule.

1. **CMS should increase the *de minimis* premium amount from $2 per member per month to $5.** Alternatively, CMS could consider basing the *de minimis* on a percentage of the NAMBA, as a longer-term transition, in case the NAMBA increases substantially due to all of the compounded changes of the IRA. The *de minimis* level is defined in guidance only at this point, not regulation,[42] and CMS could increase the level to minimize enrollee disruption in the Final Notice and Call Letter, for example.

[42] 42 CFR 423.780 states simply that a Part D plan may waive "a *de minimis* amount" but does not define the amount itself.

2. **CMS should permit Part D plan sponsors to offer a fourth PDP in a region that is LIS-only for plan year 2024 and 2025.** To further reduce enrollment churn, CMS should also allow a fourth PDP that is designated for the LIS population. Their needs often differ significantly from the non-LIS population, and one way CMS could reduce overall costs is to allow plans to create benefit designs that specifically engage this population's needs. Having a fourth plan in place will also reduce enrollment churn year to year during assignment and reassignment periods. We recognize that the current limit of three plans per region was codified in 2021, for plan year 2022.[43] We recommend CMS consider engaging CMMI or other existing waiver authority[44] to protect LIS beneficiaries for a time-limited period under this other authority.

***PCMA recommendation*: In implementing the eligibility expansion for full LIS, CMS should reduce plan reassignments by increasing the de minimis and use its demonstration authority to allow plan sponsors to offer a fourth, LIS-only plan for 2024 and 2025.**

B. Financial Guardrails to Protect Part D Plans and Beneficiaries

Through the IRA, Part D enrollees will see cost sharing relief beginning in plan year 2023, by limiting cost sharing for covered insulins and Advisory Committee on Immunizations Practices (ACIP) recommended vaccines. In 2024, eligibility increases for the LIS program, and non-LIS enrollees will no longer face coinsurance during the catastrophic benefit phase. The Coverage Gap Discount Program (CGDP) is replaced by a new Manufacturer Discount Program (MDP) starting in 2025, and beneficiaries can opt to "smooth" large pharmacy cost sharing by paying over several months.

These benefit design changes are financed in part by shifting the liability of these costs onto pharmaceutical manufacturers, Part D plan sponsors, and taxpayers. To mitigate some of the cost increase on plans, Congress included a temporary retroactive subsidy payable to Part D plan sponsors since these changes for insulins and vaccines were not included in the Final Rate Notice and bids for plan year 2023. Beginning in 2024, CMS will adjust direct subsidy amounts paid to Part D plans to limit any increases in beneficiary base premiums to no more than six percent (the "premium stabilization program" or PSP). Importantly, PSP is designed to minimize premium impact on the aggregate. CMS does not propose any regulatory definitions for PSP in this rule, leaving many questions unanswered.[45] Therefore, beyond

[43] 86 Fed. Reg. at 5864, January 19, 2021.
[44] We wish to remind CMS had the HHS OIG Part D Rebate Rule been finalized, CMS had committed to use its Section 402 authority to operate a narrowed risk corridor demo program to minimize premium effects of the policy.
[45] For example, we remain unclear on the funding source for any premium overage beyond 6% of the baseline benchmark premium.

PCMA

PSP, CMS should consider updating risk corridor and risk adjustment programs as well, under its existing authority.[46]

Risk corridors in Part D are designed to protect plans if their enrollees' prescription drug costs are much higher than expected and provide savings to CMS if plans instead overbid for providing these benefits. By narrowing the risk corridors–currently set at 5% above or below the expected cost–to something more like 2.5% above or below, plans will be able to bid with more certainty, having less to "lose" if they underbid.

In contrast to risk corridors, which protect plans from significant losses at the end of the year, risk adjustment is a prospective CMS program that helps reduce risk based on the plan's actual enrollment, over the course of the year, paid through the Direct Subsidy. Plans are protected against having an unusually unhealthy population and CMS is protected against plans ending up with unexpectedly healthy enrollees. However, CMS indicates in the CY2024 Advance Notice that there has not been sufficient time for the agency to update the risk adjustment model for 2024 given the timing of the passage of the IRA. This makes the need for narrowed risk corridors even more pressing to account for the changes related to the maximum out-of-pocket costs (MOOP), $35 copay cap for covered insulin products, vaccines at $0, and LIS expansion.

Both risk corridors and risk adjustment are important programs that keep plans participating in the Part D program. We recognize that Congress intended for PSP to be the mechanism by which additional plan and program risk would primarily be mitigated. However, having narrower risk corridors and more finely-tuned risk adjustment is an important "belt and suspenders" approach CMS should consider, for CY2025 and beyond. Given that there are significant questions about funding for PSP, any additional methods CMS can use under current law to reduce risk should be explored, including its existing demonstration authority.

***PCMA recommendation*: CMS should declare in the final rule and eventual Final Notice that it is exercising its existing authority on risk corridors and risk adjustment to help manage premium increases on beneficiaries.**

C. PBMs Can Administer the Direct Negotiation Pricing for Part D Covered Drugs

PBMs can help CMS solve a major operational challenge created by Part D covered drugs subject to direct negotiation: how will pharmacies be held harmless? Pharmacies will continue to purchase drugs through wholesale channels at wholesale prices, not at the MFP determined by CMS. We recommend that CMS leverage the new MDP, which replaces the

[46] We acknowledge that in the Advance Notice, CMS has declined to update the risk adjustment and risk corridor programs for CY2024 to address the IRA's changes. See We acknowledge that in the Advance Notice, CMS has declined to update the risk adjustment and risk corridor programs for CY2024 to address the IRA's changes.

current CGDP. In theory, the mechanisms under which MDP operates are identical to the CGDP, just at different discount levels and in two benefit phases, not one. Layering the MFP assessment into the same system minimizes the number of touchpoints needed on any one claim. We lay out a proposed process below.[47]

Part D plans currently reimburse pharmacies the lower of ingredient cost or the contracted negotiated price, minus beneficiary cost sharing. Comparing multiple prices is built into the PBM-pharmacy claims adjudication process already, for example, to ensure beneficiary copays do not exceed the covered ingredient cost amount. Plans will need to have loaded the MFP prices as "negotiated price" in order to calculate beneficiary cost sharing under the law. This means the PBM has all the data it and CMS needs to be the main intermediary.

The pharmacy then holds the risk on the difference between ingredient cost and MFP. Therefore, for MFP-priced drugs, to keep pharmacies whole, PBMs would need to pay the higher of invoice or negotiated price for these drugs, in a flip to current procedures, minus beneficiary cost sharing. Again, PBMs can do this because they already have built the logic to protect beneficiaries from extremes.

Upon paying the pharmacy the full ingredient cost rather than negotiated price minus cost sharing, the PBM would send the necessary data on this claim to a third-party administrator (TPA), as it does under the CGDP today. (We imagine this can happen monthly, just like with CGDP and presumably the future MDP.) The TPA would then bill manufacturers of the MFP-priced drugs for the difference between pharmacy acquisition cost and plan-covered amount. Manufacturers would dispute or pay. The TPA would then distribute funds back to the covering plans.[48]

We expect the replacement for CGDP – the new 10% and 20% MDP – would operate substantially identically to the existing CGDP. A process to hold pharmacies harmless should fit neatly into that same framework, without creating any new procedures for Part D plans, the TPA, or manufacturers. Further, operating MDP and MFP in the same system is the best solution because MFP-priced drugs are excluded from MDP. This has the added benefit of reducing unnecessary manufacturer disputes, if the same TPA is processing both kinds of discounts in the same way, and in the same time frame.

[47] We note that CMS has opened an Information Collection Request on the initial draft manufacturer agreement for the MDP. PCMA will be filing separate and additional timely comments on this draft. See 88 Fed Reg 7976, February 7, 2023.

[48] This is identical to how the Coverage Gap Discount Program works today. Plans send data on claims in the Coverage Gap to Palmetto GBA, the CGDP TPA, each month. Palmetto invoices manufacturers based on these data, resolves disputes, receives the payments from the manufacturers, and distributes payments back to Part D plans quarterly.

***PCMA recommendation*: CMS should indicate in the final rule that it will administer the pricing of drugs subject to direct negotiation in a manner similar to, and in conjunction with, the new Manufacturer Discount Program set to begin in 2025.**

III. Updating and Incorporating Long-standing Program Guidance into the Code of Federal Regulations

In 2019, the U.S. Supreme Court ruled in favor of plaintiff Allina Health Services, finding that CMS must undertake notice-and-comment rulemaking prior to changing any "rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing the scope of [Medicare] benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits."[49] In the intervening years, we have discussed the implications of this case with CMS and are wholly aware that much of the current Part D program operates through subregulatory guidance, built to clarify terms codified in federal regulations at the program's outset in 2005. We fully understand the monumental undertaking it is for CMS to revise its regulations to account for up to 17 years of program guidance. We appreciate that in one rule CMS cannot completely update the regulatory framework for the program. We have offered—and hereby continue to offer—our support in identifying and prioritizing guidance that is either incomplete, outdated, or where multiple versions may be contradictory.

While Herculean in size, this effort is also critical to get right. Each MA and Part D plan sponsor relies on up-to-date guidance to design its benefits and comply with all of the important beneficiary protections. CMS's network of regulations and guidance is vast, and spans contract terms with first tier downstream contractors like PBMs, which administer many of the Part D plan functions. CMS also limits how plans can be marketed to potential enrollees, and determines rights and obligations for contracted network providers, pharmacies, and enrollees. There are limited arenas designated by the federal statute in which state governments can also influence the operation of MA and Part D within their boundaries. Nine of the 34 PDP regions include more than one state; having to follow multiple state rules beyond the federal standards adds significant administrative expense to plan operations. Having a single, clear, national standard published in the Code of Federal Regulations (CFR) for these and other topics will reduce confusion among all regulators (state or federal), plan sponsors and their contractors, and beneficiaries and their advocates, helping to provide a uniform benefit to all Part D enrollees.

In the sections below, we provide comment on a handful of CMS's content, where we have substantive input to what CMS is proposing. We are not commenting on each provision in the rule that CMS seeks to codify. Our lack of comment does not mean a full endorsement of any given policy, just merely that there is no substantive change to the guidance that we recommend at this time.

[49] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019)

PCMA

A. Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (§§ 422.101, 422.112, 422.137, and 422.138)

CMS makes several proposals for MA plans to ensure their coverage determinations and utilization management (UM) protocols mirror coverage decisions made within traditional Medicare and holding the plans to these decisions for specified durations and transitions. We wish to raise five considerations for CMS, regarding (1) related rulemaking, (2) recognition of existing PBM procedures, (3) caution regarding tying private market coverage criteria to traditional Medicare, (4) being careful about transitions in Part B drug therapy, and (5) too broadly defining the applicability period of a prior authorization (PA).

First, while PCMA generally does not comment upon pure MA proposals, there is related rulemaking open that would touch upon the electronic health information exchange aspects of this topical area.[50] We ask that CMS ensure that both rules, once final, are coordinated in both approach and implementation time frames.

Second, many of the processes described by CMS regarding MA coverage determinations and UM mirror existing requirements in the Part D program. Acknowledging that the rule would only modify MA regulations, we respectfully ask that CMS explicitly differentiate Part B drugs from other covered items and services. Under an MA-PD, the contracted PBM may play a role in coordinating all prescription drug decisions, based on previous CMS regulations allowing for step therapy and prior authorizations to "cross" the two benefits. For this reason, CMS should clarify that the existing Part D portion of the plan's Pharmacy and Therapeutics (P&T) committee is sufficient for meeting the requirements under the proposed rule. CMS should also clarify that P&T committees are designed for the exclusive review of determining coverage for pharmaceuticals, not non-drug covered items and services.

Third, CMS proposes to bring MA coverage more in line with traditional Medicare, when a better shift would instead be to open traditional Medicare to the kinds of competition that MA is able to generate to reduce costs and improve outcomes. This proposal counteracts its own stated goals. It reduces consumer choice, if all MA plans cover what traditional Medicare covers, how the traditional program covers it. It complicates medical decision-making, traditional coverage policies are often vague and reliant on the contractor's final decision rather than clearly stated in summary benefit documents, and it raises costs for all. Today MA plans have flexibility to perform medical management (e.g., having a patient try conservative

[50] 87 Fed. Reg. 76238, December 13, 2022. Comments for this regulation are not due until March 13, 2023. It would require that MA plans improve the electronic exchange of healthcare data and streamline processes related to prior authorization, while continuing CMS' drive toward interoperability if finalized in current form.

therapies before surgery, redirecting a patient to a safer or more cost-effective site of care, etc.). CMS is saying that this is 'plan developed' criteria that will not be allowed to be used in addition to an applicable National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or other Medicare rule that applies to MA plans. Traditional Medicare is not set up to do medical management or very much in the way of prior authorization. As managed care plans, MA organizations are structured to perform case management services. It's part of how MA plans achieve the results that they do. The proposed rule would limit MA plans from performing the "managed" part of "managed care."

Fourth, there are complexities with Part B drugs that could make it very challenging to tell if a patient is already taking one when they join a plan (either switching to a new MA-PD or a new PDP). Under MA-PDs, PBMs often process Part B drug claims, or play a role in the organizational determination aspect of coverage, but not in all cases. The new plan may cover a given drug under a different benefit than the prior plan. Under PDPs, Parts A and B claims data access is prohibited to be used for coverage determinations. CMS needs to recognize in both cases that the full transitional coverage period might be needed to verify the appropriateness of continued care with the drug.

Finally, CMS proposes to require PAs be valid for the entire "course of treatment." The current standard is that the PA is valid for the rest of the plan year. However, it introduces serious concerns regarding cost-containment that should not be overlooked. One extreme interpretation could be requiring a lifetime approval duration for maintenance medications. The proposal restricts a tool that plans use to prevent overutilization of drugs. Overutilization can increase costs, harm patients, and prevent or delay a switch to a more appropriate treatment. It also restricts an important tool that plans use to limit fraud, waste, and abuse, as recognized by CMS's precluded prescriber program. Instead, we recommend CMS offer plans the flexibility to define both a minimum and a maximum time period for PAs. P&T committees are best positioned to ensure approval durations are not overly restrictive. Otherwise, this rule may create a situation where there is no clear time limitation and potentially no limitation on a provider continuing to furnish services.

***PCMA recommendation*: We appreciate CMS's intent in clarifying the coverage requirements applicable to MA but are concerned that the proposed rule would implicate unrelated areas, and otherwise raise costs.**

B. Review of Medical Necessity Decisions (§§ 422.566, 422.590, and 422.629)

We appreciate that CMS is carrying over to the MA regulations much of the language that has been applied to Part D plan sponsors since plan year 2012.[51] CMS's goal here should be to completely align the two programs, rather than have distinguishing differences. In many organizations, the same teams operate the coverage determination (CD) and organization

[51] 76 Fed. Reg. at 21576, April 15, 2011.

determination (OD) processes. Having them apply the same criteria regarding which clinician can render a denial of an initial coverage request will best reduce burdens. With this in mind, we offer the following recommendations for the final rule:

1. **CMS should add complementary language to 42 CFR 423.566.** We agree with CMS's sentiment that the reviewer of an OD need not be of the same profession or specialty as the item or service being reviewed. We believe this should carry over to Part D CDs as well. CMS should add the sentence "The physician or health care professional with expertise in the field reviewing the request need not, in all cases, be of the same specialty or subspecialty as the treating physician or other health care provider," in the corresponding Part D regulatory text. We have added "with expertise in the field" to CMS's proposed sentence, to bring the Part D text in line with the Part C text in spirit. Pharmacists may be the most appropriate final reviewer for a CD or an OD. CMS in the rule writes that plans should be able to decide the appropriate reviewer for each OD (and thus CD). We encourage CMS to memorialize this in the regulatory text, as well.

2. **CMS should identify other ways to reduce burdens on MA and Part D plan sponsors.** PCMA remains convinced that CMS should lighten burdens on plans further by allowing pharmacists to play additional roles on redetermination requests.[52] The initial check on a redetermination is that everything required is submitted. Under current guidance, only a medical director can make that determination. This adds undue cost to plan sponsors and diminishes the role of pharmacists in community and managed care settings. We note that most of the guidance appearing in the current appeals and grievances chapter is not yet being codified by CMS.[53] This guidance is critical to plans and advocates alike and should be high on CMS's list, going forward.

3. **CMS should take care to quantify these changes and all guidance-to-regulation changes.** Because preceding guidance to this rule change was never captured in formal administrative budgets, the time and money burden of this proposal does not reflect the actual costs incurred by PBMs and plans to perform ODs and CDs.

***PCMA recommendation*: We support codifying this longstanding process under MA with the caveat that CMS should not require that there be an exact match between the service requested and the qualifications of the medical director reviewing the request. We request CMS consider aligning the Part D rules to match the new language. We also request CMS consider allowing Part D coverage redeterminations to be initially reviewed by pharmacists.**

[52] Letter from Tom Barker, of counsel to PCMA, to HHS OGC. April 30, 2019. Attached to this letter as supplemental material.
[53] The updated Appeals and Grievances chapter was last published in August 2022, 3 years after *Allina*. Available at: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf.

C. Part C and Part D Midyear Benefit Changes and Part D Incorrect Collections of Premiums and Cost Sharing (§§ 422.254, 423.265, 423.293, 423.294)

CMS proposes to codify its existing guidance prohibiting midyear benefit enhancements (MYBE), outside of CMS-approved or maintenance formulary changes, that would reduce premiums or "bid-level" cost sharing after the beginning of the marketing period. We will focus on CMS's proposals regarding the Part D regulations, rather than those under MA.

CMS's proposal would establish a *de minimis* threshold for refunds and recoveries associated with incorrect collections of premiums and cost sharing. We support this proposal in principle as we have found that very small refunds generate an abrasion with beneficiaries and complaints asserting the plan sponsor is being wasteful. As proposed, this approach limits administrative costs, which in turn creates savings that can be passed along to beneficiaries. There are a few considerations CMS should reconcile, however, in a final rule:

1. The proposed rule reads as if the *de minimis* would be optional. We recommend CMS make the threshold mandatory, otherwise enrollees who switch plans may be confused.

2. CMS does not need to fully align Parts C and D regulations in this instance, because prescription claim processing differs significantly from medical claim processing. Prescription claims adjustments affect the enrollee's True out-of-pocket (TrOOP), including pushing someone into or out of the coverage gap. There is no similar cliff in MA – the out-of-pocket (OOP) maximum is much more transparent. At the claims level, pharmacies aren't sending monthly bills for unpaid cost sharing, and increasing or reducing cost sharing at the POS instead would require significant programming time, and likely new National Council for Prescription Drug Program (NCPDP) standards.

We also want to raise several concerns to CMS on a few areas that need further specification prior to finalization. This proposal does not align with the six-year overpayment lookback period CMS proposes to also codify, elsewhere, at §§ 422.326(c), 423.360(c), and (§ 401.305(a)(2). Further, numerous situations can cause overpayments and underpayments, but almost always require adjusting one or more claims (and related Prescription Drug Events (PDES)) or deleting PDEs (which typically results in claim adjustment activity). These activities most often result in changes to a beneficiary's financial accumulators, not only on the claim that was initially affected, but on multiple claims that had financials predicated on the original state of the affected claim. In other words, when one claim changes, it often affects other claims for that beneficiary for that plan year.

If CMS intends the adjustment activity should not be performed at all for affected claims that are older than the specified three-year lookback, the overpayment requirements would need to be changed to three years to align with the adjustment time frames, as there would be no

other way to correctly identify and calculate all the financial impacts resulting from an identified issue for plan years prior to the three-year time frame. Alternatively, does CMS intend claims outside the three-year lookback period (but within the six-year overpayment lookback period) be adjusted to correct the payment with CMS, but that a plan would not be allowed to initiate reimbursements or recoveries with the beneficiary, the pharmacy, or any other payers or other involved entities (e.g., long-term care (LTC) facilities), based on the resulting financial changes caused by these adjustment activities? If so, a plan would have no way to recoup their losses when an overpayment is identified and corrected. If this is the case, how does CMS want these losses reported?

Finally, we appreciate the in-place waiver under the COVID-19 public health emergency (PHE) declaration, intended to ensure adequate pharmacy access (cost-sharing waivers) that would otherwise violate the uniform benefit provisions. We request that CMS offer a transition period on this waiver, including into plan year 2024, should some or all of the covered items and services affected by the waiver not yet be either fully U.S. Food and Drug Administration (FDA) approved[54] or be available as commercial stock.[55]

***PCMA recommendation*: CMS should finalize this proposal, with modifications to not fully align Part D and MA rules, further consideration given to the overpayments provision of the rule, and regarding the post-PHE expectations.**

D. Call Center Interpreter Standards (§§ 422.111(h)(1)(iii)(A) and 423.128(d)(1)(iii)(A)) and Call Center Teletypewriter (TTY) Services (§§ 422.111(h)(1)(iv)(B) and 423.128(d)(1)(v)(B)) and Updating Translation Standards for Required Materials and Content (§§ 422.2267 and 423.2267)

CMS proposes several changes framed as codifying existing guidance with regard to language access plans (LAP) for individuals with limited English proficiency (LEP). First, it proposes to codify and clarify standards for interpreters available to enrollees by phone. Second, it would require that teletypewriters assistance be available to callers within seven minutes of the call. Third, CMS proposes to update its marketing and communications standards, such that plans would be required to have materials available in an enrollee's stated preferred language and in auxiliary form, if requested. CMS justifies this latter rule change by describing its work with Medicare-Medicaid Plans (MMPs), noting the prevalence

[54] As CMS is aware, Congress's FY2023 Omnibus Appropriations bill requires Part D plans to cover as "covered Part D drugs" any oral antiviral available under an Emergency Use Authorization (EUA) to treat COVID-19 through plan year 2024. The waiver need not include this additional language, but the existing waiver on collecting cost-sharing and ability to pay (and how to report) pharmacy dispensing fees should persist through plan year 2024 for continuity.

[55] It remains unclear how many doses of US government purchased doses (USG) of the two oral antivirals remain circulating. Even if or when these drugs receive full FDA approval, USG stock may still be circulating. CMS's waiver extension should apply to USG doses only, not commercially acquired product.

of non-English speaking beneficiaries, and those with difficulty hearing or reading, and linking these vulnerabilities to a higher likelihood of decreased health outcomes. Under the rule, once a plan becomes aware of an individual's needs it must honor all requests in the individual's preferred format. PCMA and its members are sympathetic to CMS's concerns and support this specific proposal. We offer several recommendations and considerations below on how to achieve the remainder of CMS's aims in a less burdensome manner.

First, as CMS acknowledged in last year's 2023 proposed rule, changes to other HHS regulations regarding LAP are underway. While we appreciate that for plan year 2023, CMS simply reverted to preceding rules, in this rulemaking CMS is instead aiming to codify an expected behavior. We ask that CMS ensure any requirements imposed on Part D plans are consistent and implemented in coordination with changes issued by the HHS Office of Civil Rights (OCR). As of this writing, OCR's final rule is expected this spring. For this reason, CMS should delay the requirements of this rule, since any change in OCR regulations that CMS wishes to impose on Part D plans will not have been available for public comment. At worst, CMS should "gate" any new requirements on them being compatible with the new OCR rule and defer any enforcement until plan year 2025. This will afford the industry sufficient time to sort out the new OCR requirements across all affected lines of business. A one-year delay will also provide plans sufficient time to set up the IT resources necessary to support fulfilling multiple language/fulfillment requests on a standing basis.

Second, in response to CMS's proposals on interpreter standards, TTY toll time and standing requests for non-English language materials, we recommend CMS consider several process efficiencies, and a number of open questions we have, before finalizing the language as proposed:

1. **Alternative delivery mechanisms.** Non-English physical materials production is typically outsourced, and three days is not enough time for Braille documents produced on demand, especially if it is non-English Braille. CMS should provide flexibility for plans to meet the time requirement in other ways. If the individual has a named Representative, could delivery of the materials to the appointment of representative (AOR) meet CMS's needs while the plan works to provide the document to the individual? Or would the delivery of a document via an e-reader be sufficient rather than Braille printed materials? Or could a plan offer telephonic translation services to the member, by bringing a translator or TTY on the line to help answer any questions in lieu of fulfilling the document in the alternate format?

2. **Single, national standards can simplify processes.** CMS cites its learnings from MMPs to justify the need for standing requests for these materials. As CMS is aware, one of the reasons it took so long to launch, the Medicare-Medicaid Plans (MMPs) was trying to navigate the differences in state law compared to CMS marketing guidance. Will CMS issue a single national standard to simplify all Part D communications – including among

MMPs – despite the Medicaid tie-in to that program? If CMS is so inclined, working across its silos to create a single Medicare **and Medicaid** standard would also be beneficial to participants.

3. **Alternative format requests.** How do enrollees request alternative formats? Can a Representative make the request? Can CMS provide model scripting to plans to discuss alternate format/translation requests with members? Enrollees may not understand what they are asking for, and then have more questions about the document they received instead. For example, many request large print but then are unhappy with the amount/type of paper received which results in grievances.

4. **Has CMS considered development model documents in large print and the 15 nationally most-common languages and Braille and Spanish Braille?** Having plans create these themselves based on the CMS model document, rather than CMS undertaking the work as a one-time expense, when they are likely contracting for similar work for the traditional Medicare program, seems unnecessarily burdensome on plans. If plans had a library of CMS-endorsed translations available, delivery would be more streamlined as well. Large print documents are difficult to convert from regular size print; it requires essentially an entire new typeset and layout, at additional expense for each plan sponsor.

5. **Can CMS and plans incorporate English language literacy into addressing social determinants of health?** As CMS noted in the rule convincingly, non-English speakers achieve worse health outcomes. What are CMS's expectations, and has it considered the role that its model documents can play in leveling the field in regard to English proficiency?

6. **Non-standard notices and time frames.** Beyond the model documents provided by CMS in English and Spanish, there are also many communications that are unique to an individual's specific situation that would need to be separately translated. Many of these communications, such as a UM decision or a care plan, need to be communicated very quickly to the beneficiary. The need for translation must be balanced with the need to provide many non-standard communications quickly. Turnaround times would be the most challenging element of this requirement. For accessible formats and auxiliary aids—given the complexity of audio, data, and braille conversion—the request for a unique document to be converted can take two to four weeks to complete. For unique documents to be translated into another language, the turnaround time is one to two weeks. This completion time runs counter to the need to provide many unique communications quickly. If CMS is intent on finalizing this requirement relative to non-standard communications, it would be critical that CMS first establish multi-stakeholder workgroups on how language translations and conversions to aids could be accomplished more quickly for nonstandard communications.

7. **Can CMS produce a definitive list of required materials?** Is 42 CFR 422.2267(e)(1) the current and complete list of materials that CMS expects to be translated or available in alternative formats? Some of these are categories rather than uniquely identified materials. We are concerned that we may not feel a document is called out in the list, but in actuality CMS still expects it translated.

8. **Medicaid requirements.** Also, within the rule, CMS is proposing that plans be required to adhere to both Medicare and state specific Medicaid requirements for a wide variety of plan types. We are requesting that CMS incorporate these state specific requirements into HPMS, along with the Medicare requirements. This will save plans from having to find the information themselves and keep everyone consistent in the languages they are using.

9. **Standing Basis.** CMS should clarify its expectations around what "on a standing basis" means. PBMs receive eligibility files from plan sponsors with language indicators. In one month, the file may list a language, and then the following month it may be missing. Are PBMs obligated to honor the original language indicator, in perpetuity?

***PCMA recommendation*: CMS should finalize this proposal but only with respect to standard documents, which CMS could ideally produce models for to streamline delivery. Plans will still need time to translate specific situational communications beyond what CMS would otherwise allot. CMS should delay any requirements on those types of communications pending further stakeholder feedback.**

E. Medicare Advantage (MA) and Part D Marketing (Subpart V of Parts 422 and 423)

In this rule, CMS is addressing several years of growing concerns regarding the marketing approaches taken by plans and their contracted third-party marketing organizations (TPMOs). PCMA supports CMS's effort and offers additional justification for the codification of these and other similar national standards. CMS's proposed actions in this rule will make clear to the market there is a single enforcer of a clear, beneficiary-focused standard.

1. **Uniform national standards are needed.** While state partnership is important, it is critical to preserve and strengthen the role of standardized, federal rules to ensure consistency in addressing misleading marketing materials across the country. A patchwork of state regulations on MA and Part D marketing materials would undermine strong and consistent federal standards and risk inconsistent enforcement regimes. Many of CMS's concerns are around television advertising. State-based differences could provide for loopholes or uneven enforcement. This is clearly the outcome Congress intended when it included the broad federal pre-emption clause in the MA and Part D authorizing statute.

2. **CMS should go beyond this proposal and codify additional Part C and D marketing requirements that exist elsewhere.** Since the regulatory and subregulatory requirements currently in effect related to marketing are not published in one place for stakeholders to reference, we recommend CMS compile and codify the various marketing requirements that exist within the Medicare Communications and Marketing Guidelines (MCMG) and clarifying HPMS memos. As with this rulemaking, CMS should provide the public with an opportunity to comment.

***PCMA recommendation*: We support CMS's efforts to protect beneficiaries from false and misleading advertising and ask that it further codify its other marketing guidance in the future.**

F. Changes to an Approved Formulary (§§ 423.4, 423.100, 423.104, 423.120, and 423.128)

CMS is proposing to codify its Prescription Drug Benefit Manual chapter on midyear formulary changes and the several updates it has provided to plan sponsors outside of the Manual via HPMS.[56] PCMA is fully supportive of codifying these changes, to create a single national standard. **We ask that CMS also extend the final rule to allow the immediate substitution biosimilars of the reference product as well.** If a reference product must compete directly with a biosimilar, beneficiaries and the Medicare program will achieve the potential of savings at a much quicker pace. The prescriber and patient community are looking to CMS to definitively state that biosimilars are safe and effective for the Medicare population. The status quo merely protects innovator reference biologics, at the expense of the Medicare program and its beneficiaries.

We acknowledge that FDA's interchangeability designation is enshrined in the ACA and in federal regulation. However, those regulations are about drug manufacturer approval pathways, and represent a further example of big drug companies erecting barriers to competition, rather than meaningful clinical distinctions across products. Many drugs that are "mere" biosimilars here are treated as wholly interchangeable in Europe for more than a decade. We point CMS to a recent report released by IQVIA that demonstrates that the introduction of an interchangeable biosimilar dramatically reshaped the insulin market, in a way that predecessor biosimilars did not.[57] CMS's formulary regulations should step outside of FDA's shadow and recognize that FDA-licensed biosimilars are safe and effective. Formulary regulations should also recognize that biosimilars of the same reference product are biosimilars of each other, and biosimilars are therapeutic substitutes for other reference products in the same therapeutic class.

[56] See Q5 in HPMS, CY 2022 Formulary Information, December 27, 2021.
[57] IQVIA Institute for Human Data Science, "Biosimilars in the United States 2023-2027." January 31, 2023. Available at https://www.iqvia.com/insights/the-iqvia-institute/reports/biosimilars-in-the-united-states-2023-2027.

***PCMA recommendation*: CMS should expand its proposal, to also allow for the immediate substitution of biosimilar products for their reference product.**

G. Part D Proposed Automatic Shipment Requirements (§ 423.505)

PCMA has a long history of supporting simplification of the Part D program's auto-ship requirements. We appreciate that CMS is tackling this issue in this rulemaking, and pulling existing guidance up to the regulatory level, which will standardize the administration of these programs across the country. In the rule, CMS proposes to adopt most of the guidance provided by manual chapter and HPMS memo since its last rulemaking (2014), with a few exceptions. We recommend CMS revise its proposal in the following ways:

1. **CMS should adopt the language used in the 2020 Final Call Letter on plan approximations.**[58] This guidance, not referenced in the proposed rule, allows for plans to provide an approximate shipping date range (e.g., two to three days) in lieu of an exact date. As CMS is aware, through our shared experience with the COVID-19 PHE and any number of weather-related events, exact shipping and receipt dates are an unmanageable standard to meet. The 2020 guidance further permits plans to provide approximate cost-sharing amounts for an upcoming shipment, rather than the exact cost-sharing amount. Since beneficiaries may still be acquiring some drugs at retail pharmacies rather than through the mail, there's a chance that someone could trigger a new benefit phase while the automatic shipment is still in process.

2. **CMS should reduce the notification requirement to a single printed and mailed letter.** Plans repeatedly received phone calls from beneficiaries about receiving too much mail and confusion arises about whether something has changed when they receive a second letter.

***PCMA recommendation*: We support the codification of Part D automatic shipment requirements and recommend CMS use the 2020 Call Letter as its basis for allowing plan flexibility on shipment dates and approximate cost sharing.**

IV. Request for Comment on the Rewards and Incentives Program Regulations for Part C Enrollees (§ 422.134 and Subpart V)

CMS seeks comment on potential revisions to the MA regulations regarding rewards and incentives (R&I), based on a change in the standard of what a "cash equivalent" is according to

[58] CMS, Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, April 1, 2019. Available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf. See pages 230*ff*.

the HHS, OIG. We appreciate that CMS has made no proposal here, so plans operating in 2024 are not going to have to make sudden changes in their offerings. We continue to believe that Part D plan sponsors and their enrollees would benefit from RI designed with similar guardrails as the MA policy allows would bring an additional layer of health improvement activities to PDP enrollees. For example, under the MA Value-Based Insurance Design (VBID) CMMI model, MA plans were able to offer R&I based on enrollees meeting adherence goals for medications.[59] While we acknowledge there is not similar language in the Part D authorizing statute, we ask that CMS consider alternative authorities to achieve these aims. We suggest CMS find a way to continue to allow MA plans to offer cash equivalent R&I, and also to extend offerings to PDPs.

***PCMA recommendation*: CMS should identify a path forward to maintain or improve the ability of MA and Part D plan sponsors to offer enrollees cash equivalent rewards and incentives.**

V. Revisions to the Medication Therapy Management (MTM) Program

CMS has proposed significant structural reforms of the Medication Therapy Management (MTM) program. The current MTM program, in CMS's view, has seen decreasing enrollment and a lack of attention from Part D plan sponsors. Enrollment is voluntary, and plan and PBM outreach have not persuaded people to participate at high enough rates. Under the rule, plans would have to make a broader set of Part D enrollees eligible for MTM. CMS estimates that as many as 11 million enrollees may become eligible, up from about 4.5 million participants in MTM programs today.

PCMA is concerned about the CMS MTM program proposed changes. While PCMA supports a well-constructed MTM program, we are troubled that CMS is proposing a major expansion without considering either the significant implementation problems or other less burdensome ways to achieve a robust MTM program. Moreover, the proposal lacks a fundamental assessment as to why making more beneficiaries eligible to enroll into MTM is the optimal outcome. We also note a number of other viable options to improving MTM that CMS should consider. Rather than conduct such a wholesale swap in the midst of significant and serious changes to the Part D program under the IRA, CMS should engage the stakeholder community and determine alternative options for satisfying MTM statutory requirements, given all of the other plan offerings available today. At a minimum, we ask that CMS delay any effective date for changes to the MTM program to plan year 2025. Below we outline our concerns and offer a range of alternatives for consideration.

A. **What About Increased Engagement for Currently Eligible Beneficiaries?** CMS's drastic expansion of MTM threatens to miss an opportunity to have plans better target and engage those already eligible. If participation is low, then casting a wider net to a less

[59] RAND. Evaluation of Phase II of the Medicare Advantage Value-Based Insurance Design Model Test. Available at https://innovation.cms.gov/data-and-reports/2022/vbid-1st-report-2022.

needy population will not generate more engagement, just more participants. Withdrawing or at a minimum delaying the significant proposed MTM expansion would allow plan sponsors to focus on the existing eligible population that has the greatest need, avoid diluting the program, and be more consistent with the Administration's health equity goals.

B. **How much does it cost?** CMS acknowledges that its three-fold approach to eligibility expansion would more than double the number of MTM participants, yet states are unable to score the proposal because of unclear administrative costs. Any proposal that would increase eligibility by 6.5 million enrollees to a voluntary program – roughly the same number of Medicare beneficiaries in all of California[60] – must be "economically significant" regardless of presumed administrative costs and require a burden estimate before CMS can reasonably expect meaningful public input. In the final rule, CMS should offer such an analysis while delaying any action on the proposal itself.[61] Importantly, any additional costs incurred as a result of the expansion of the MTM program would be in addition to premium pressures from other policies that will go into effect in 2024 including changes from the IRA and the change in the definition of negotiated price – or pharmacy DIR at point-of-sale.

C. **How will CMS know what works and what doesn't?** The three-fold approach to expansion also means that CMS will be unable to determine which part of their expansion "worked" or "failed" when it is evaluated.[62] The metrics for MTM success for CMS (vaguely defined as related to reducing medication errors, improving health outcomes, and "maintaining a reasonable cost criterion") are ill-defined. If plans are not able to reduce medication errors beyond today's reductions with the expanded eligibility, is it because so many new enrollees had fewer than eight medications? Or maybe the

[60] Per https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly/monthly-enrollment-state-2023-01, there are 6.7 million Medicare beneficiaries eligible for MA or Part D plan enrollment in California as of January 2023.

[61] Such an estimate should include costs such as: (a) information system changes and testing; (b) myriad plan operational and policy changes (e.g. need to go to specified sources for determination of maintenance drugs); (c) changes to enrollee materials, handbook, and mailings; (d)new training materials for employees; and (e) new education and training content for MTM providers. This list is of course in addition to the cost of conducting more CMRs which CMS has projected to be in the range of $336 million annually.

[62] CMS did not reference the CMMI "Part D Enhanced MTM Model" (eMTM Model) which ended in 2021. eMTM sought to test "whether modifications to traditional MTM requirements incentivize better medication management interventions and thereby lead to improved therapeutic outcomes and reductions in Medicare expenditures." [see: Part D Enhanced Medication Therapy Management Model | CMS Innovation Center. The Fourth Evaluation Report found that there were limited if any benefits from the various eMTM interventions to expand MTM to a broader population.[see: Evaluation of the Enhanced Medication Therapy Management (MTM) Model: At a Glance (cms.gov)]. There does not appear to be a final eMTM evaluation. In any event, due to the consistency of what the Model was looking at and the current CMS goals to improve MTM, at a minimum, CMS should conduct a "lessons learned" type assessment based on the eMTM Model findings.

baseline for errors is exceedingly low when the cost threshold invites participants on five stable, low-cost generic medications, whose potential errors have already been worked out. CMS will not know, yet PBMs will have expended millions of dollars in resources – yielding higher premiums for all Part D enrollees including those who participate in MTM – with no clear reason as to why. CMS also fails to address the main threshold question with MTM, which is how to engage unwilling eligible enrollees. In the final rule, CMS should instead consider a staged expansion, in a design that tests which facet yields the best outcomes. For instance, requiring eligibility based on a reduced number of drugs, first, could test whether Comprehensive Medication Reviews (CMRs) are effective for a broader set of individuals.

In addition to failing to recognize the earlier CMMI demo on enhanced MTM in the proposed rule, CMS also does not discuss the more recent expansion of MTM to include all at-risk or potentially at-risk beneficiaries (ARBs and PARBs) who are concurrently enrolled in Drug Management Programs (DMPs). ARBs and PARBs have a demonstrated claims history indicating they may have been prescribed a significant level of opioids. Under the SUPPORT Act, CMS was to design a DMP to monitor both the beneficiary and their prescribers and inform them of the risks. All DMP beneficiaries were automatically enrolled in MTMs beginning in 2021. Has CMS conducted any evaluation of this mandatory expansion? Did MTM build upon or distract from the purposes of the DMP?

D. **What about Star Ratings?** MTM participation affects Star Ratings in a number of ways, most directly through the CMR measure, which would need to be moved to display status given all the changes, but also through complaints tracking, adherence itself, and other chronic disease measures. While a change that affects all plans would seem to have a monotonic effect on all plans' Star Ratings, that is not the case, given the highly variable enrollment and mix of chronic conditions across the country. Further, reduced quality bonus payments would have the result of reducing the availability of MA supplemental benefits that target improvements in health equity-aligned measures.

E. **What about all the other programs in operation?** In our view, one concern CMS may be expressing is that much of what they considered to be MTM programming is occurring outside of the formal program. MA-PDs – which have a much more aligned incentive to achieve MTM goals than standalone PDPs – often employ case management and social determinant of health (SDOH) programming that incorporates the core concepts of MTM, and more, for populations beyond those enrolled in their formal MTM programs. They are achieving significant health outcomes improvements, though the results are not matriculating to MTM. In other cases, much of what MTM covers can be conducted in an automated fashion, without individual participant at all, e.g., drug-drug interaction (DDI) analyses, which are performed routinely outside of CMRs. Could CMS instead consider redefining what counts as MTM and accepting a broader conception of case

management as being compliant with the Part D requirements? In a similar vein, since the incentives for MA-PDs to operate MTM and MTM-like case management are clear, could CMS devise ways for PDPs to share in any Part A and B fee-for-service (FFS) medical benefits savings they generate?

F. **Can CMS help individuals understand the value of MTM or similar programs?** As CMS is aware, many individuals eligible for MTM choose not to participate. Could CMS consider changes to MPF that would highlight the value added by specific plans' MTMs? Would CMS consider their own outreach during the Annual Enrollment Period to potentially eligible enrollees providing them guidance on why selecting plans based on MTM program specifics may be beneficial? Beneficiary groups could be engaged to determine what changes may help make enrollees more receptive to participating in CMRs.

G. **CMS should engage the stakeholder community through a working group.** There is a recent precedent for convening a broad and diverse group. CMS in 2019-2020 engaged plans, PBMs, developers, and patient groups on how to improve MPF which resulted in major improvements supported by a wide range of interested parties. Plans and PBMs could be engaged to determine what other programs they have that currently substitute for the MTM program, to determine whether MTM expansion is warranted.

H. **CMS should re-issue any initiative it is considering to expand the MTM program as a Request for Information (RFI).** There are several questions CMS asks in the proposed rule that should be understood before any proposal is offered. CMS should ask these questions in a future RFI to inform the stakeholder workgroups we are recommending. These questions include those on eligibility criteria (e.g., whether to include cancer as a monolith core chronic condition), the effect of including any additional core chronic diseases on specialized MTM provider training and program size, and whether MTM services are an effective mechanism for management of certain diseases (e.g., those with high use of Part B drugs or frequently changing medication regimens). These seem to be questions CMS should understand prior to proposing a several-hundred-million dollar increase in plan expenditures and premium increases on beneficiaries.

***PCMA recommendation*: CMS should not finalize this proposal. It should instead undertake a stakeholder engagement exercise to determine which aspects of the MTM program are worth going forward. In addition, CMS should provide more flexibility to help plan sponsors reach the thousands of beneficiaries who are already MTM eligible but not yet engaged.**

VI. Revisions to the Medicare Overpayment Provisions of the Affordable Care Act (§§ 422.326(c), 423.360(c), (§ 401.305(a)(2))

CMS has proposed to revise the standards by which a plan sponsor identifies an overpayment, by adopting the False Claims Act definition of "knowing" and "knowingly." Under the proposed rule, an MA organization or Part D sponsor has identified an overpayment if it has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment. The context for this change is related to litigation over earlier rulemaking on overpayments in 2014, and confusion over revisions made in 2016 that sought to address the litigation. We appreciate CMS's efforts to clarify this important area of program integrity, but a few questions remain.

First, we ask that CMS clarify that there is still a need for an investigation period. While a plan may identify, or be made aware of, a potential overpayment, only through further investigation would it be able to identify the reason and make corrective action.

Second, we appreciate that CMS is working to align the MA and Part D regulations with the FFS regulations promulgated in 2016. However, in capitated models like MA and Part D, it's not clear how a repayment to CMS would work outside of annual reconciliation programs. MA and Part D plans are paid a risk adjusted per-member per-month (PMPM) amount by both CMS and the beneficiary. Beneficiaries then pay cost sharing to providers and pharmacies for covered items and services. (This simplifies an obviously more complicated process). An identified overpayment by beneficiaries as cost sharing is more readily actionable by plans than an overpayment by CMS or beneficiaries as subsidies or premiums, since the PMPM payments are not paying for specific items.

***PCMA recommendation*: CMS should clarify the continued need for an investigation period and further clarify how plans that receive overpayments on capitated rates would calculate and return these amounts.**

VII. Proposals intended to streamline the adoption of electronic health information interchange

A. Standards for Electronic Prescribing (§ 423.160)

CMS proposes updates to the standards that Medicare Part D plans will use for electronic prescribing (e-prescribing). CMS notes that it is proposing a "novel approach" to updating e-prescribing standards by cross-referencing relevant standards adopted by the Office of the National Coordinator for Health Information Technology (ONC) and those adopted in the Health Insurance Portability and Accountability Act (HIPAA). CMS states that the NCPDP SCRIPT standard version 2022011 offers important updates and efficiencies for the healthcare industry and would be a suitable e-prescribing standard for the Medicare Part D

program. CMS also proposes this NCPDP SCRIPT standard for the Part D medication history transactions and electronic prior authorization (e-PA) transactions, following a transition period from July 1, 2023 until January 1, 2025. Use of NCPDP SCRIPT version 2022011 would have a mandatory compliance deadline of January 1, 2025. CMS also notes that NCPDP has developed a Real-Time Prescription Benefit (RTPB) standard for use with an electronic real-time benefit tool (RTBT) and that NCPDP RTPB standard version 12 is designed for prescribers, not RTBT applications used by beneficiaries. CMS proposes that prescribers' RTBTs must comply with NCPDP RTPB standard version 12 by January 1, 2025. CMS emphasized, however, that it is not proposing that the NCPDP standard be required for beneficiary RTBTs.

PCMA has long-supported both e-prescribing and e-PA and believes that both tools increase transparency for health care consumers. E-prescribing ensures that each prescription is written by a valid prescriber and filled by a legitimate pharmacy, which improves patient safety and quality by reducing medication errors. Similarly, e-PA can streamline the PA process, saving both prescribers and PBMs administrative costs, while helping to prevent fraud, waste, and abuse. PCMA fully supports the use of e-PA as a means to improve provider and patient satisfaction and reduce inefficiencies in care delivery, such as access to prescribed medications and treatment.

***PCMA recommendation*: CMS should update the e-PA standard to NCPDP SCRIPT version 2022011, with a transition period for NCPDP SCRIPT from July 1, 2023 until January 1, 2025. CMS should not delay the mandatory compliance deadline beyond this date.**

B. Adoption of Health IT Standards (45 CFR 170.205)

ONC proposes to adopt standards for e-prescribing and other relevant activities on behalf of HHS, including for use by the Part D program. The new department-wide approach is intended to increase alignment within HHS and to reduce regulatory burden for stakeholders. Prior to this effort, the ONC Health IT Certification program and the Medicare Part D program have had separate standards for e-prescribing, medication history, and e-PA for prescription drugs. ONC and CMS are pursuing a new approach whereby ONC and CMS would adopt the same standards and align the requirements for use of those standards within each of their programs. CMS notes that alignment across the standards will provide for consistent regulatory requirements for Part D plan sponsors, health care providers, and health IT developers. CMS proposes that during a transition period – from the effective date of a final rule until January 1, 2025 – both the 2017-01 and 2022011 versions of the NCPDP SCRIPT standard would be available for use, with only the 2022022 version being available on or after January 1, 2025. CMS seeks comment on whether it should allow for a transition period up to January 1, 2026 or longer.

***PCMA recommendation*: CMS should align the standards and requirements for electronic prescribing and related activities across the Part D program and ONC Health IT Certification program. CMS should also allow for a transition period which should not be extended beyond 2026.**

C. Other Considerations-Updating NCPDP Telecommunication Standard Implementation Guide, Version F6 Standards and Competing Priorities

CMS's alignment of standards and requirements should include the proposed adoption of the NCPDP Telecommunication Standard Implementation Guide, Version F6 (Version F6) and equivalent NCPDP Batch Standard Implementation Guide, Version 15 (Version 15) in relation to all other changes taking place within the Medicare program.

PCMA agrees that implementation of Version F6 and Version 15 will mitigate existing inefficient workarounds, allow for more robust data exchanges between LTC providers and payers, improve coordination of benefits information, improve controlled substances reporting, codify clinical and patient data, harmonize with related standards, and improve plan benefit transparency. Version F6 and Version 15 would provide greater clarity in data exchanges between pharmacies and payers, improve reporting for various programs, eliminate complex workarounds, and improve plan coordination of benefits and transparency.

Given the complexity of the new F6 standard, PCMA believes that a 36-month implementation period with an additional transition period of eight months is necessary. This will allow sufficient time for IT development and internal testing, external testing, and certification, and then production deployment. For this reason, we support both a longer implementation period plus a transition period to perform stage testing, configuration, and implementation. Therefore, PCMA requests the compliance date be set 44 months after the final rule effective date for NCPDP Telecommunication Standard Version F6 and Batch Standard Version 15.

The additional time is necessary not only for successful implementation of the new standards, but also to accommodate the many changes required for successful implementation of the Inflation Reduction Act (IRA) provisions as well as other technology changes such as adoption of health IT standards, which are happening concurrently. PCMA is concerned that many of the same resources will be needed to address and implement IRA provisions affecting the Medicare program, updated health IT standards and electronic prescribing. This will create a significant challenge in terms of competing priorities and severe resource constraints, which could jeopardize the smooth implementation of both the new standards and the IRA requirements.

***PCMA recommendation*: CMS should finalize an F6 compliance date 44 months after the effective date of the final rule and ensure that stakeholders have sufficient time to develop and test changes before rolling them out.**

VIII. Changes to the Medicare Part C & D Star Ratings program

PCMA supports CMS's goals for the delivery of equitable and consistent, high-quality coordinated care to Medicare beneficiaries through measure updates, including measure additions, removals, and updates based on specification and performance changes. We applaud CMS's efforts at integrating measurement and quality with equitable care which requires the consideration and analysis of SDOH, such as geographic location, housing, transportation, co-morbidities, education, race, sex, and gender, among others. Assessment of such SDOH factors allows for integrated whole-person care that addresses medical and behavioral health needs through the lens of non-clinical social factors. However, PCMA recommends clarity of SDOH measurement goals and definitions to promote uniformity in care delivery and assessment. In addition, equity and equitable care is also affected by administrative factors such as measure weighting, guardrails, and extreme and uncontrollable circumstances.

A. Adding, Updating, and Removing Measures §§ 422.164 and 423.184

- **Proposed Measure Updates.** Medication Adherence for Diabetes Medication, Medication Adherence for Hypertension (RAS Antagonists), Medication Adherence for Cholesterol

CMS is proposing a substantive update to implement risk adjustment based on sociodemographic characteristics regarding medication adherence for three measures: (1) diabetes medication; (2) hypertension medication (RAS antagonists); and (3) cholesterol medication (statins). CMS proposes to implement risk adjustment based on measure specifications recommended by the Pharmacy Quality Alliance (PQA). If finalized, these risk adjustment adherence measures would be display measures for two years beginning with the 2026 Star Ratings, then replace the legacy measures as Star Ratings in 2028.

In addition to risk adjustments to the three adherence measures, CMS proposes to eliminate adjustments for In-Patient (IP)/Skilled Nursing Facility (SNF) stays. These inpatient stays do affect Proportion of Days Covered (PDC) calculations and disproportionately disadvantage vulnerable populations with sicker and medically complex members. Therefore, this is as much a measurement issue as it is a SDOH issue. Without risk adjustments offsetting this potential impact, we cannot support this proposal. Given that LTC facility staff manage this complicated population with scarce

resources, alignment is needed with respect to who is accountable once a patient enters LTC.

From a patient care lens, interactions with LTC facility staff are often unnecessary and take time away from actual patient care. Moreover, LTC facilities are held to quality standards that are measured which includes medication reviews by clinical staff. Given this duplication, we would suggest that CMS exclude members residing in LTC facilities, since these members are being managed by professional care teams and medications are actively monitored. Additionally, LTC billing practices like batch billing play more of a role in declining PDC calculations than lapses in doses and complicates the true view of adherence.

PCMA appreciates CMS's continued commitment to further exploring sociodemographic status (SDS) measures. However, we recommend that CMS not finalize the proposed updates for the reasons that follow. The agency's proposed rule references a June 28, 2020, Office of the Assistant Secretary for Planning and Evaluation (ASPE) Report to Congress[63] which recommended the implementation of social risk factors (SRFs) but does not provide insight into a definition of success regarding adherence measures. Perfect adherence is not attainable, and there is no discussion of a "ceiling" of adherence that would translate into a rating. Therefore, the lack of specificity surrounding an identifiable goal for the measure would harm beneficiaries.

In addition, removal of the stand-alone Part C Medication Reconciliation Post-discharge measure will have a negative impact on adherence, as post-discharge medication reconciliation is one of the best opportunities for intervention to ensure adherence. PCMA also believes that the proposed changes would place beneficiaries in a precarious position, as the proposed change would dissuade plans from taking on sicker populations with SDS characteristics associated with poor adherence. In addition, we do not support the proposed removal of the post-discharge medication reconciliation measure.

***PCMA recommendation*: CMS should not make the proposed substantive changes to the diabetes medication, hypertension medication, or cholesterol medication adherence measures for the 2026 Star Ratings measurement year.**

[63] Second Report to Congress on Social Risk and Medicare's Value-Based Purchasing Programs, *ASPE*, https://www.aspe.hhs.gov/reports/second-report-congress-social-risk-medicares-value-based-purchasing-programs.

PCMA

B. Proposed Measure Additions

- **Kidney Health Evaluation for Patients with Diabetes (Part C)**

CMS is proposing to add a kidney health evaluation for MA patients with diabetes to the 2026 Star Rating year. CMS began reporting this measure as a display measure for the 2022 Star Ratings. PCMA is strongly supportive of this measure, as it aligns with NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) portfolio measure.[64]

***PCMA recommendation*: CMS should adopt the Kidney Health Evaluation for Patients with Diabetes measure for the 2026 Star Ratings.**

- **Concurrent Use of Opioids and Benzodiazepines (COB), Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults (PolyACH), and Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults (Poly-CNS) (Part D)**

CMS is proposing to add a new performance measure that would measure Concurrent Use of Opioids and Benzodiazepines (COB) in Part D for the 2026 Star Ratings. The measure examines concurrent use of prescription opioids and benzodiazepines in Medicare Part D beneficiaries beginning at age 18. While PCMA understands the risks of concurrent use of prescription opioids and benzodiazepines, we believe the proposed measure is overly broad and would not be effective in reducing complications and overdoses for beneficiaries.

PCMA notes that the Centers for Disease Control and Prevention's (CDC) updated opioid prescribing guidelines[65] clearly state that decisions regarding concurrent use of opioids and benzodiazepines involve several considerations between a physician and patient. Identifying "enrollees who are at risk of respiratory depression or fatal overdoses, cognitive decline, or falls and fractures"[66] was considered by CDC to be a Category B recommendation, which classifies attention to prescribing opioids and benzodiazepines as an individual-level concern that does not apply to all persons. PCMA does not believe that CMS should develop measures and incentives that are at odds with the policies of the new CDC guidelines.

PCMA also believes that any necessary interventions regarding tapering off existing medications are the role of the physician – plans and PBMs do not have control of these

[64] Kidney Health: A New HEDIS Measure, *NCQA*, https://www.ncqa.org/blog/kidneyhealth/.
[65] CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022, *The Centers for Disease Control and Prevention*, https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_w.
[66] 87 Fed. Reg. at 79619.

decisions. In addition, opioid prescribing concerns are often addressed at the physician-level through enhanced Concurrent Drug Utilization Review (CDUR) Edits. CDUR Edits require additional steps from physicians when co-prescribing an opioid and a benzodiazepine through a soft reject. This safety edit is readily used and addresses co-prescribing concerns at an effective care level.

Should CMS adopt this measure, PCMA recommends that it be more targeted to effectively reduce adverse outcomes and be limited to patients who are newly using these medications concurrently, as long-time users of both medications are significantly less likely to experience adverse events.[67] Due to the logistical difficulties of coordinating concurrent use of opioids and benzodiazepines between physicians and health plans, limiting intervention to the first 30 days of concurrent use would be the most effective and feasible window to achieve desired results.

***PCMA recommendation*: CMS should rescind its proposed addition of the Concurrent Use of Opioids and Benzodiazepines measure.**

CMS is also proposing to add two new polypharmacy measures for: (1) Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH), and (2) Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults (Poly-CNS). The Poly-ACH measure would analyze the percentage of Part D beneficiaries with concurrent use of at least two ACH medications, and the Poly-CNS measure would calculate the percentage of Part D beneficiaries using three or more CNS-active medications concurrently. If finalized, these measures would go into effect for the 2026 Star Ratings. Should CMS adopt the measure, it should be limited to patients who are newly using these medications concurrently.

Data related to polypharmacy use is difficult to collect and burdensome for providers. It is also unclear as to which metrics and outcomes would be considered successful for this measure. This lack of clear goals for measurement exacerbates our concern that these new measures would not substantially improve patient outcomes.

While the agency notes that the goal of this measure is for "plans to encourage appropriate prescribing when clinically necessary,"[68] it is unclear how plans and PBMs are well situated to improve polypharmacy use compared to prescribers, who are better situated to understand a beneficiary's medical history and medication needs. Much of the research guiding CMS's proposal to include these new polypharmacy measures cites the

[67] Hernandez I, He M, Brooks MM, Zhang Y. Exposure-Response Association Between Concurrent Opioid and Benzodiazepine Use and Risk of Opioid-Related Overdose in Medicare Part D Beneficiaries, *JAMA Network Open*, 2018;1(2):e180919. doi:10.1001/jamanetworkopen.2018.0919.
[68] 87 Fed. Reg. at 79619.

Beers Criteria for Potentially Inappropriate Medication (PIM) Use in Older Adults[69] which shows low to moderate evidence, reiterating PCMA's recommendation regarding the need to collect robust and useful data.

PCMA recommendation: CMS should revoke its proposal to implement the Poly-ACH and Poly-CNS measures for the 2026 Star Ratings.

C. Measure Weights (§§ 422.166(e) and 423.186(e))

- **Patient Experience/Complaints and Access Measures (§§ 422.166(e)(1)(iii) and (iv), 423.186(e)(1)(iii) and (iv))**

Beginning with the 2026 Star Ratings, CMS is proposing to decrease the weight of patient experience and complaint measures to two. In its final rule in 2020, CMS had increased the weight of patient experience and or complaints from two to four for the 2023 Star Ratings. In this proposed rule, CMS states that it has reconsidered its position from the 2020 final rule and now believes that these measures currently are receiving an undue weight in the Star Ratings. PCMA concurs with CMS's assessment.

PCMA recommendation: CMS should decrease the current weighting of patient experience and / or complaints measure from four to two.

D. Guardrails §§ 422.166(a)(2)(i) and 423.186(a)(2)(i)

CMS is proposing to eliminate the guardrails that restrict the maximum allowable movement of non-Consumer Assessment of Healthcare Providers and Systems (CAHPS) cut points. This would modify the cut points for non-CAHPS measure stars. The guardrails have been in place so that the cut points for these measures did not increase or decrease more than the cap amount from year to year. If finalized, the guardrails would be removed for the 2026 Star Ratings.

With this proposed change, we believe that CMS must redefine its goals for success to adequately obtain the reward factor associated with CAHPS measures. Additionally, the lack of guardrails generates questions about an appropriate adherence percentage for cut points, as 100 percent adherence, for example, would not be an achievable goal for a 5-star rating.

PCMA recommendation: CMS should redefine its goals for success to adequately obtain the reward factor associated with CAHPS measures.

[69] American Geriatrics Society 2019 Beers Criteria Update Expert Panel. Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults. J Am Geriatr Soc. 2019 Apr;67(4):674–694. PMID: 30693946.

E. Health Equity Index Reward (§§ 422.166(f)(3) and 423.186(f)(3))

CMS has created a Health Equity Index (HEI), which it proposes to use in the Part C and D Star Ratings that would reward plans with high scores for their enrollees with certain SRFs. CMS states that the HEI reward is designed specifically to create an incentive for plans to reduce disparities in care and improve health equity. CMS proposes to define HEI as "an index that summarizes contract performance among those with specified [SRFs] across multiple measures into a single score." CMS would replace the current reward factor with the new HEI reward starting with the 2027 Star Ratings.

PCMA has long supported efforts to increase quality for Medicare beneficiaries. Part D plans invest considerable resources on a long-term basis to increase plan performance and make improvements in their Star Ratings. We support CMS's efforts to improve health equity, though we suggest that the agency further clarify how the HEI would be applied and its impact on Star Ratings. In addition, it is critical that plans have access to the data that CMS utilizes in order to ensure that appropriate populations are being analyzed. In order for CMS to achieve its equity goals in an effective and efficient manner, we believe that more work needs to be done to target populations that can most benefit. In its current form, the proposal does not specify which SRFs would be leveraged or a specific intended outcome for the HEI measure.

In its discussion regarding the HEI reward, CMS notes that it agrees with the definition of SRFs that was established by the National Academies of Sciences, Engineering, and Medicine (NASEM). This definition is vague and would compound the unanswered questions surrounding the HEI definition. [70] A lack of specificity and clarity regarding a potential HEI measure and SRFs could also create an adverse incentive for cherry picking and beneficiary selection based on SRFs, and the reward factor would likely penalize plans that already have robust SDOH mechanisms integrated into their services.

In short, we believe that there is too much ambiguity surrounding the proposed HEI measure and definition to move forward with the agency's proposal at this time and that more work needs to be done to improve the HEI measure reward.

Should the agency maintain its support of the measure, we recommend a two-year display measure period to gather additional information on the HEI's impact, ways to achieve data goals, which populations to target, how to reconcile the reward factor for plans that already have robust SDOH initiatives in place, and the ultimate outcome goal for the measure.

Should CMS decide to move forward with the HEI measure, PCMA recommends a transition period for implementation, where the HEI measure would be a display measure for two years

[70] Social Risk Factors: Definitions and Data Accounting for Social Risk Factors in Medicare Payment, *The National Academies Press*, https://nap.nationalacademies.org/read/23635/chapter/4.

while CMS assesses the above issues. We also believe that a hold harmless provision would be appropriate to avoid adverse impacts on plans that already engage in SDOH efforts.

***PCMA recommendation*: CMS should withdraw the proposed HEI measure.**

F. Improvement Measure Hold Harmless §§ 422.166(g)(1) and 423.186(g)(1)

CMS is proposing to lift the hold harmless provision for 4- and 4.5-star contracts due to the fact that those plans still have the potential to improve and increase their measure scores and Star Ratings, leaving the hold harmless to apply only to 5-star plans. If finalized, this provision would be applied to the 2026 Star Ratings.

PCMA applauds CMS for its sustained dedication to encouraging plan improvement as a means to better serve beneficiaries. However, we think CMS needs to consider a range of issues before finalizing this change. CMS should be aware that this change will cause the Tukey method to pull down total Star Rating scores since outliers are more commonly low-performing data points. This change will undoubtedly have a negative impact on plans and beneficiaries, as maintaining Star Ratings will become more difficult and require more plan resources.

Historically, we have found the known threshold cut points at the 4-star level provided the utmost clarity and predictability for plans. Fluctuating goalposts surrounding cut points not only enhances uncertainty but also does not provide adequate time to fully realize the adverse consequences of these changes. Constant methodological changes such as this proposed change systematically deprive beneficiaries of plan improvement to comply with new standards that risk further decreasing plans' ratings.

Additionally, performance is often driven at a regional level even if Star Ratings are scored at a national level. Factors like culture, demographics/social determinants of health, infrastructure, differences in healthcare administration, prescriber behavior, etc., drive quality performance. While there are areas of the country that tend to perform well and drive cut points on the high end, there are areas of the country, especially in areas that were heavily impacted by COVID and have not fully recovered. For these areas a 4- or 4.5-star may be the highest achievable rating. Therefore, a hold harmless on plans achieving a 4-star or above allows some cushion to account for those regional differences.

***PCMA recommendation*: CMS should revoke its hold harmless proposal to maintain consistency and predictability and not drain resources from plans.**

G. Extreme and Uncontrollable Circumstances §§ 422.166(i)(9)(i), 422.166(i)(10)(i), 423.186(i)(7)(i), and 423.186(i)(8)(i)

CMS is proposing to remove its extreme and uncontrollable circumstances rule, which applied when 60 percent or more of a contract's enrollees were in individual assistance areas designated by the Federal Emergency Management Agency (FEMA). CMS would limit the rule to Star Ratings for 2025 and earlier. CMS states that, for non-CAHPS measures in 2026 and beyond, if a contract is affected by an extreme and uncontrollable circumstance and has a significantly lower score on a measure, the score would be removed if it is an "extreme outlier." CMS states that removal of the 60 percent rule will simplify the Star Ratings calculations. Given that CMS has not provided a definition of extreme outlier and the percentage of enrollees affected by this change is unknown, more data is needed prior to removing the extreme and uncontrollable circumstances rule.

PCMA recommendation: CMS should not remove the extreme and uncontrollable circumstances rule without undertaking a comparative analysis of the data.

H. Calculation of Star Ratings §§ 422.166(a)(2)(i) and 423.186(a)(2)(i)

CMS is proposing to maintain its previously published final rule[71] to implement Tukey outlier deletion beginning with the 2024 Star Ratings, though the agency intends to finalize a technical change to rectify a codification error from that final rule. PCMA disagrees with the impending implementation of the Tukey outlier deletion, as it will have a negative impact on Star Ratings, as exemplified in the Tukey Outlier Deletion Simulations data file.[72] Hurdles to improving scores will likely impact plans' attitudes towards goals of improving scores.

PCMA recommendation: CMS should withdraw its proposed Tukey outlier deletion for the 2024 Star Ratings as it will create new hurdles for plans that are trying to improve their ratings.

IX. Transitioning away from Public Health Emergency (PHE)-related policies for Coronavirus-19 covered items and services

On January 30, 2023, the White House announced that the current COVID-19 PHE will expire effective May 11, 2023.[73] This announcement did not address the level of leftover government procured vaccines and antivirals, nor did it address commercial access and procurement given

[71] 87 FR 27766
[72] Tukey Outlier Deletion Simulations (ZIP), Part C and D Performance Data, *CMS.gov*, https://www.cms.gov/files/zip/tukey-outlier-deletion-simulations.zip.
[73] CMS, Current Emergencies, see https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page. Last updated February 2, 2023.

that these products are still being used under the Emergency Use Authorization (EUA) designation. Moreover, commercial access is dependent on full FDA approval of products with the availability of necessary NDC codes.

Since the start of the COVID-19 pandemic, access to antiviral therapeutics and COVID vaccines has been facilitated by and dependent on the PHE declaration, FDA EUA designations, and government-purchased supply of both products. FDA EUAs and government purchase and distribution of EUA tests and therapeutics eased access for insured and uninsured individuals. These federally procured products are provided at zero cost to all regardless of coverage, including with respect to copays and coinsurance.

Given that the PHE is ending, plans and PBMs will need guidance and confirmation of CMS's outlook on coverage and cost sharing for COVID-19 tests, vaccines, and treatments. As plan sponsors are constructing their plan offerings for 2024, some but not all COVID-19 tests, vaccines, and treatments (or indications thereof) will be either available only under an EUA or as government-purchased stock. Since the commercial pricing of these items remains unknown, CMS should clarify for manufacturers what level of UM (including but not limited to PA and cost sharing) Part D plan sponsors may impose on these services once commercially available.

With the end of the PHE set for May 2023, CMS should focus on tracking of government procured supply of both vaccines and antiviral medications as those supplies get depleted and replaced by commercially procured supplies. CMS should also address coverage with regards to FDA approval status of vaccines and antivirals, including copay and coinsurance parameters.

Moving forward coverage will also be affected by the 2023 Omnibus Bill Sec. 4131[74] which encourages continued coverage of oral antiviral drugs available only under an FDA EUA and dispensed pursuant to a prescription through December 31, 2024. PBMs will continue to facilitate appropriate clinical use of these therapies. These operational considerations mostly stem from the emergence of new COVID variants, changes in clinical guidance, and practice recommendations, false positive and negative test results. The role of UM post-COVID will be to help providers and pharmacists with respect to clinical appropriateness given that they may not be able to keep up with the clinical changes in real time.

Apart from coverage and access, the other important issue relates to the transition period from PHE to post-PHE period. Since the PHE is ending in May 2023, documents, operational, and administrative processes should not change midyear. The focus of unwinding should be on plan year 2024 materials post-PHE for minimizing beneficiary confusion and operational burdens. This will help the facilitation of commercial units throughout 2023 as government supplies get depleted and PBMs ready themselves for new administrative processes post-PHE.

[74] H.R.2617 - 117th Congress (2021-2022): Consolidated Appropriations Act, 2023. (2022, December 29). https://www.congress.gov/bill/117th-congress/house-bill/2617

***PCMA recommendation*: We recommend that CMS align COVID PHE unwinding with plan year 2024 and formally acknowledge the appropriateness of UM for commercial units of the oral antivirals and monoclonal antibodies for the Medicare program.**

CMS Is Not Required By the Inflation Reduction Act of 2022 to Revise the Current Regulatory Definition of Gross Covered Prescription Drug Costs

Section 11001 of the Inflation Reduction Act of 2022 (IRA)[1] requires the Department of Health and Human Services (HHS) to negotiate the prices Medicare pays for certain prescription drugs under Part B and Part D. In describing the drugs that are eligible for negotiation, the statute defines "total expenditures" by referencing, for Part D drugs, total "gross covered prescription drug costs (as defined in section 1860D-15(b)(3))."[2] Congress also cross-referenced the gross covered prescription drug costs definition to implement the Manufacturer Discount Program in the IRA.[3]

The term "gross covered prescription drug costs" has, since 2005, been interpreted by the Centers for Medicare & Medicaid Services (CMS) to mean "those **actually paid** costs incurred under a Part D plan, excluding administrative costs, but including dispensing fees, during the coverage year."[4] The "actually paid costs" include the share of actual costs actually paid by the Part D plan, nominal cost-sharing paid by or on behalf of an enrollee, and all amounts paid under the Part D plan by or on behalf of an enrollee.[5] In the Medicare Contract Year 2024 Policy and Technical Changes Proposed Rule,[6] CMS proposes to amend the definition of "gross covered prescription drug costs" to remove the phrase "actually paid."

We have been asked whether CMS is required by the IRA to amend its definition of "gross covered prescription drug costs" to remove the phrase "actually paid." We believe the answer is no, CMS is not required to amend its definition of gross prescription drug costs. As explained below, it is reasonable to conclude that Congress was aware of, and accepted, CMS' established definition of gross covered prescription drug costs, including the phrase "actually paid," when it cross-referenced the definition for purposes of the new programs.

Our opinion is limited to the issues specifically identified herein and does not address any other issues. The analysis and conclusions expressed in this opinion are based upon the laws, regulations, rulings and decisions currently in effect, all of which are subject to change, and are

---

[1] P. L. 117-169.

[2] Social Security Act § 1191(c)(5), as added by § 11001 of the IRA; 42 U.S.C. § 1320f.

[3] Social Security Act § 1860D-14C, as added by § 11201 of the IRA; 42 U.S.C. § 1395w-114c.

[4] 42 C.F.R. § 423.308 "Gross covered prescription drug costs" (emphasis added).

[5] 42 C.F.R. § 423.308.

[6] Centers for Medicare & Medicaid Services, Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications, Proposed Rule, 87 Fed. Reg. 79452 (Dec. 27, 2022) (Proposed Rule).

subject to the limitations and qualifications set forth herein. It is possible that a court or HHS could reach conclusions different from our own.

I. Legal Background

A. Medicare Part D

In 1965, Congress amended the Social Security Act, through the Health Insurance for the Aged Act, to create Medicare.[7] Originally, Medicare consisted of Part A (hospital coverage) and Part B (supplementary coverage–*e.g.*, physician services). Those eligible for Medicare coverage included individuals who are age 65 or over and are eligible for Social Security retirement (or would be eligible for such benefits if certain government employment were covered employment under such title) or under the railroad retirement system. Outpatient prescription drug coverage was not part of the original Medicare program.

The Medicare program was amended in 2003 to add voluntary prescription drug coverage (Part D).[8] CMS issued a final rule in 2005 implementing the new Part D benefit,[9] and has issued rules implementing and revising requirements periodically since that time.

One Part D program feature is subsidized coverage for certain eligible beneficiaries.[10] In 2003, Congress created two subsidies: a direct subsidy and a "subsidy through reinsurance." The reinsurance-based subsidy

> is an amount equal to 80 percent of the allowable reinsurance costs (as specified in paragraph (2)) attributable to that portion of gross covered prescription drug costs as specified in paragraph (3) incurred in the coverage year after such individual has incurred costs that exceed the annual out-of-pocket threshold specified in section 1395w-102(b)(4)(B) of this title.[11]

"[A]llowable reinsurance costs," in turn, means

> with respect to **gross covered prescription drug costs** under a prescription drug plan offered by a PDP sponsor or an MA-PD plan offered by an MA organization, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or organization or by (or on behalf of) an enrollee under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were basic

[7] P.L. 89-97.

[8] Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173)

[9] Centers for Medicare & Medicaid Services, Medicare Prescription Drug Benefit, 70 Fed. Reg. 4193 (Jan. 28, 2005).

[10] Social Security Act § 1860D-15.

[11] Social Security Act § 1860D-15(b)(1) (2003).

> prescription drug coverage, or, in the case of a plan providing supplemental prescription drug coverage, if such coverage were standard prescription drug coverage.[12]

And "gross covered prescription drug costs"[13] means

> with respect to a part D eligible individual enrolled in a prescription drug plan or MA-PD plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year and costs relating to the deductible. Such costs shall be determined whether they are paid by the individual or under the plan, regardless of whether the coverage under the plan exceeds basic prescription drug coverage.[14]

B. Inflation Reduction Act

Among many other things, the IRA created a program under which HHS is required to negotiate prices with pharmaceutical manufacturers for certain Medicare-covered drugs (the Drug Price Negotiation Program). In creating and implementing this program, Congress amended the Part D subsidy definitions described above and, in the Drug Price Negotiation Program, cross-referenced the statutory definition of "gross covered prescription drug costs."

1. Gross covered prescription drug costs amendments

When Congress amended section 1860D-15 (the Part D subsidy provision) in 2010 and again in 2020, it did not make any substantive changes to the definition of gross covered prescription drug costs.[15] In 2022, however, Congress amended section 1860D-15 substantively. In the IRA, Congress changed the subsidy payment percentage amounts, changed the definition of allowable reinsurance costs, and changed the definition of gross covered prescription drug costs (used to determine allowable reinsurance costs).

Following the IRA, the gross covered prescription drug costs provision reads (changes in italics):

> *Subject to paragraph (2)(B),* for purposes of this section, the term "gross covered prescription drug costs" means, with respect to a part D eligible individual enrolled in a prescription drug plan or MA-PD plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year and costs relating to the deductible. Such costs shall be determined whether they are paid by the individual or under the plan *(or, with respect to 2025 and subsequent years, in the case of an applicable drug, as defined in section 1395w-114c(g)(2) of this title, by a manufacturer)*, regardless of whether the coverage under the plan exceeds basic prescription drug coverage.

---

[12] Social Security Act § 1860D-15(b)(2) (2003) (emphasis added).

[13] "Gross covered prescription drug costs" is sometimes abbreviated by CMS as GCPDC.

[14] Social Security Act § 1860D-15(b)(3) (2003).

[15] Pub. L. 111-148, Title VI, § 6402(b); Pub. L. 116-206, Div. CC, Title 1, § 112(a).

And, for these purposes, "applicable drug" means a covered Part D drug, but does not include a drug selected by HHS for negotiation during a specified period.[16]

2. Drug Price Negotiation Program

The Drug Price Negotiation Program requires HHS to negotiate the prices Medicare pays for certain prescription drugs under Part B and Part D. The IRA directs HHS to select "negotiation eligible" drugs.[17] In establishing the Program, Congress provided definitions of various terms used in the Program, including "total expenditures."

> The term "total expenditures" includes, in the case of expenditures with respect to part D of subchapter XVIII, the **total gross covered prescription drug costs (as defined in section 1395w-115(b)(3) of this title)**. The term "total expenditures" excludes, in the case of expenditures with respect to part B of such subchapter, expenditures for a drug or biological product that are bundled or packaged into the payment for another service.[18]

(emphasis added). The cross-reference, section 1395w-115(b)(3), is the definition of "gross covered prescription drug costs" described above. Congress included a similar cross-reference in the Manufacturer Discount Program included in the IRA.[19]

---

[16] 42 U.S.C.A. § 1395w-114c

> (2) Applicable drug
>
> The term "applicable drug", with respect to an applicable beneficiary--
>
> (A) means a covered part D drug--
>
> (i) approved under a new drug application under section 355(c) of Title 21 or, in the case of a biologic product, licensed under section 262 of this title; and
>
> (ii)(I) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA-PD plan uses a formulary, which is on the formulary of the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in;
>
> (II) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA-PD plan does not use a formulary, for which benefits are available under the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in; or
>
> (III) is provided through an exception or appeal; and
>
> (B) does not include a selected drug (as referred to under section 1320f-1(c) of this title) during a price applicability period (as defined in section 1320f(b)(2) of this title) with respect to such drug.

[17] 42 U.S.C.A. § 1320f-1.

[18] 42 U.S.C.A. § 1320f.

[19] Social Security Act 1860D-14C, as added by IRA § 11201(c); 42 USC § 1395w-114c.

C. Agency Interpretation

1. Gross covered prescription drug costs

CMS issued rules shortly after the Part D program was created, interpreting the Part D drug subsidy requirements, including the gross covered prescription drug cost.[20] And in 2005, when the first Part D rule was issued, it defined gross covered prescription drug costs as

> those **actually paid costs** incurred under a Part D plan, excluding administrative costs, but including dispensing fees during the coverage year and costs relating to the deductible. They equal-
>
> (1) All reimbursement paid by a Part D sponsor to a pharmacy (or other intermediary) or to indemnify an enrollee when the reimbursement is associated with an enrollee obtaining drugs under the Part D plan; plus
>
> (2) All amounts paid under the Part D plan by or on behalf of an enrollee (such as the deductible, coinsurance, cost-sharing, or amounts between the initial coverage limit and the out-of-pocket threshold) in order to obtain drugs covered under the Part D plan. These costs are determined regardless of whether the coverage under the plan exceeds basic prescription drug coverage.[21]

In March of 2009, the gross covered prescription drug cost definition was amended.[22] At the time, CMS explained that the revision was necessary to "ensure that nominal PAP copayments are included in 'gross covered prescription drug costs' and allowable reinsurance costs."[23] CMS further explained that "Any cost incurred by a Part D sponsor under the Medicare Part D program which does not represent "gross covered prescription drug cost" incurred by the sponsor to purchase or reimburse the purchase of Part D drugs is considered an "administrative cost"."[24]

CMS further explained that the amendment to the definition of gross covered prescription drug costs was necessary to exclude certain expenses paid by the plan:

> We proposed revising the definitions of "gross covered prescription drug costs" and "allowable risk corridor costs" to establish that the amount received by the dispensing pharmacy or other dispensing provider (whether directly or through an intermediate contracting organization) and not the amount paid by the Part D sponsor to the PBM, is the basis for determining the drug costs that must be reported to CMS. This change will

---

[20] Centers for Medicare & Medicaid Services, Medicare Prescription Drug Benefit, 70 Fed. Reg. 4193 (Jan. 28, 2005).

[21] 42 CFR § 423.308 (2005)(emphasis added)

[22] Centers for Medicare & Medicaid Services, Medicare Advantage and Prescription Drug Benefit Programs: Negotiated Pricing and Remaining Revisions, 74 Fed. Reg. 1493 (Jan. 1. 2009).

[23] Centers for Medicare & Medicaid Services, Medicare Advantage and Prescription Drug Benefit Programs: Negotiated Pricing and Remaining Revisions, 74 Fed. Reg. 1493, 1504 (Jan. 1. 2009).

[24] Centers for Medicare & Medicaid Services, Medicare Advantage and Prescription Drug Benefit Programs: Negotiated Pricing and Remaining Revisions, 74 Fed. Reg. 1493, 1514 (Jan. 1. 2009).

> ensure that all administrative costs incurred by Part D sponsors, including the "risk premium" paid to PBMs to mitigate market risk around the cost of drugs, are excluded from the drug costs used to determine reinsurance and risk sharing payments.[25]

CMS justified the change, in part, by saying that "the proposed changes to the definitions of "gross covered prescription drug costs" and "allowable risk corridor costs" would increase transparency by ensuring that CMS and Part D sponsors are aware of actual Part D drug costs."[26]

In October of 2009, CMS proposed to revise the definition of gross covered prescription drug costs again, this time to "replace the term 'negotiated price' with the term 'actual cost,'" and to correct a technical error in the March 2009 definition which failed to reference usual and customary prices for out-of-network drugs.[27] CMS finalized the proposal in 2010, explaining that "our intent was to clarify that Part D sponsors must use the amount received by the

---

[25] Centers for Medicare & Medicaid Services, Medicare Advantage and Prescription Drug Benefit Programs: Negotiated Pricing and Remaining Revisions, 74 Fed. Reg. 1493, 1514 (Jan. 1. 2009).

[26] Centers for Medicare & Medicaid Services, Medicare Advantage and Prescription Drug Benefit Programs: Negotiated Pricing and Remaining Revisions, 74 Fed. Reg. 1493, 1514 (Jan. 1. 2009). The rule read as follows (changes in italics):

> Gross covered prescription drug costs *mean* those actually paid costs incurred under a Part D plan, excluding administrative costs, but including dispensing fees, during the coverage year. They equal *the sum of the following:*
>
> (1) The share of negotiated prices (as defined by § 423.100 of this part) actually paid by the Part D plan that is received as reimbursement by the pharmacy, or other dispensing entity, reimbursement paid to indemnify an enrollee when the reimbursement is associated with an enrollee obtaining covered Part D drugs under the Part D plan, or payments made by the Part D sponsor to other parties listed in § 423.464(f)(1) of this part with which the Part D sponsor must coordinate benefits, including other Part D plans, or as the result of any reconciliation process developed by CMS under § 423.464 of this part.
>
> (2) Nominal cost-sharing paid by or on behalf of an enrollee which is associated with drugs that would otherwise be covered Part D drugs, as defined in § 423.100 of this part, but are instead paid for, with the exception of said nominal cost-sharing, by a patient assistance program providing assistance outside the Part D benefit, provided that documentation of such nominal cost-sharing has been submitted to the Part D plan consistent with the plan processes and instructions for the submission of such information.
>
> *(3)* All amounts paid under the Part D plan by or on behalf of an enrollee (such as the deductible, coinsurance, cost sharing, or amounts between the initial coverage limit and the out-of-pocket threshold) in order to obtain *Part D drugs that are covered under the Part D plan. If an enrollee who is paying 100 percent cost sharing (as a result of paying a deductible or because the enrollee is between the initial coverage limit and the out-of-pocket threshold) obtains a covered Part D drug at a lower cost than is available under the Part D plan, such cost-sharing will be considered an amount paid under the plan by or on behalf of an enrollee under the previous sentence of this definition, if the enrollee's costs are incurred costs as defined under § 423.100 of this part and documentation of the incurred costs has been submitted to the Part D plan consistent with plan processes and instructions for the submission of such information.* These costs are determined regardless of whether the coverage under the plan exceeds basic prescription drug coverage.

[27] Centers for Medicare & Medicaid Services, Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 75 Fed. Reg. 19677, 19786 (April 15, 2010).

dispensing pharmacy or other dispensing provider as the basis for determining the drug costs that must be reported to us."[28]

Thus, the current rule defining gross covered prescription drug cost is more detailed than the original 2005 definition, but retains the "actually paid costs" phrase, just as it did in the original 2005 rule:

> Gross covered prescription drug costs mean those **actually paid costs** incurred under a Part D plan, excluding administrative costs, but including dispensing fees, during the coverage year. They equal the sum of the following:
>
> (1) The share of actual costs (as defined by § 423.100 of this part) actually paid by the Part D plan that is received as reimbursement by the pharmacy, or other dispensing entity, reimbursement paid to indemnify an enrollee when the reimbursement is associated with an enrollee obtaining covered Part D drugs under the Part D plan, or payments made by the Part D sponsor to other parties listed in § 423.464(f)(1) of this part with which the Part D sponsor must coordinate benefits, including other Part D plans, or as the result of any reconciliation process developed by CMS under § 423.464 of this part.
>
> (2) Nominal cost-sharing paid by or on behalf of an enrollee which is associated with drugs that would otherwise be covered Part D drugs, as defined in § 423.100 of this part, but are instead paid for, with the exception of said nominal cost-sharing, by a patient assistance program providing assistance outside the Part D benefit, provided that documentation of such nominal cost-sharing has been submitted to the Part D plan consistent with the plan processes and instructions for the submission of such information.
>
> (3) All amounts paid under the Part D plan by or on behalf of an enrollee (such as the deductible, coinsurance, cost sharing, or amounts between the initial coverage limit and the out-of-pocket threshold) in order to obtain Part D drugs that are covered under the Part D plan. If an enrollee who is paying 100 percent cost sharing (as a result of paying a deductible or because the enrollee is between the initial coverage limit and the out-of-pocket threshold) obtains a covered Part D drug at a lower cost than is available under the Part D plan, such cost-sharing will be considered an amount paid under the plan by or on behalf of an enrollee under the previous sentence of this definition, if the enrollee's costs are incurred costs as defined under § 423.100 of this part and documentation of the incurred costs has been submitted to the Part D plan consistent with plan processes and instructions for the submission of such information. These costs are determined

[28] Centers for Medicare & Medicaid Services, Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 75 Fed. Reg. 19677, 19787 (April 15, 2010).

regardless of whether the coverage under the plan exceeds basic prescription drug coverage.[29]

2. Actually paid

In 2005, CMS also defined "actually paid."[30] CMS explained that "[a]ctually paid means that these costs must be net of any discounts, chargebacks, and average percentage rebates, and will exclude any amounts not actually incurred by the sponsor."[31] The formal definition of actually paid reads:

> "Actually paid means that the costs must be actually incurred by the sponsor and must be net of any direct or indirect remuneration (including discounts, chargebacks or average percentage rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits offered to some or all purchasers) from any source (including manufacturers, pharmacies, enrollees, or any other person) that would serve to decrease the costs incurred by the sponsor for the drug."[32]

The current definition of "actually paid" reads:

> Actually paid means that the costs must be actually incurred by the *Part D* sponsor and must be net of any direct or indirect remuneration (including discounts, *charge backs* or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits offered to some or all purchasers) from any source (including manufacturers, pharmacies, enrollees, or any other person) that would serve to decrease the costs incurred *under the Part D plan. Direct and indirect remuneration includes discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits from manufacturers, pharmacies or similar entities obtained by an intermediary contracting organization with which the Part D plan sponsor has contracted, regardless of whether the intermediary contracting organization retains all or a portion of the direct and indirect remuneration or passes the entire direct and indirect remuneration to the Part D plan sponsor and regardless of the terms of the contract between the plan sponsor and the intermediary contracting organization*.[33]

---

[29] 42 CFR § 423.308 (2023).

[30] Centers for Medicare & Medicaid Services, Medicare Prescription Drug Benefit, 70 Fed. Reg. 4193 (Jan. 28, 2005).

[31] Centers for Medicare & Medicaid Services, Medicare Prescription Drug Benefit, 70 Fed. Reg. 4193, 4311 (Jan. 28, 2005).

[32] *See, e.g.*, Centers for Medicare & Medicaid Services, Medicare Prescription Drug Benefit, 70 Fed. Reg. 4193, 4398 (Jan. 28, 2005).

[33] 42 CFR § 123.308 "Actually paid" (2023)(emphasis added).

The italicized terms show the differences between the 2005 and 2023 definition; the additions were made in 2009 when CMS decided to codify then-current guidance to clarify what direct and indirect remuneration includes.[34] In that rule, CMS favorably quoted a comment that said "rebates retained by PBMs and price concessions received from manufacturers should be treated as part of the true drug cost."[35] CMS further noted that "actually paid" was intended, in part, to assist Part D sponsors identify the most cost effective drugs and help Part D sponsor in negotiations with manufacturers and PBMs.[36]

3. Proposed rule amendments to gross covered prescription drug cost

The Proposed Rule would amend the current definition so that it reads:

> Gross covered prescription drug costs means those costs incurred under a Part D plan, excluding administrative costs, but including dispensing fees, during the coverage year. They equal the sum of the following:
>
> (1) The share of actual costs (as defined by § 423.100 of this part) paid by the Part D plan that is received as reimbursement by the pharmacy, or other dispensing entity, reimbursement paid to indemnify an enrollee when the reimbursement is associated with an enrollee obtaining covered Part D drugs under the Part D plan, or payments made by the Part D sponsor to other parties listed in § 423.464(f)(1) of this part with which the Part D sponsor must coordinate benefits, including other Part D plans, or as the result of any reconciliation process developed by CMS under § 423.464 of this part. …

CMS explains that gross covered prescription drug costs (also referred to in the preamble as GCPDC) is statutorily defined, and that the statutory definition of "allowable reinsurance costs"

> specifies that such costs are the subset of GCPDC that are "actually paid (net of discounts, chargebacks, and average percentage rebates)," the statutory definition of GCPDC at paragraph (3) of that provision does not use the phrase "actually paid" or otherwise specify that such costs must be net of all DIR.[37]

CMS concludes that

> This distinction, coupled with the use of the modifier "gross" to describe these costs indicates that the best reading of section 1860D-15(b)(3) of the Act is that GCPDC should reflect gross costs, not net costs that reflect all DIR that a Part D sponsor may receive. As stated above, CMS's use of the phrase "actually paid" in the current regulatory definition of GCPDC was intended to emphasize that all DIR would be netted

[34] Centers for Medicare & Medicaid Services, Medicare Advantage and Prescription Drug Benefit Programs: Negotiated Pricing and Remaining Revisions, 74 Fed. Reg. 1493, 1512 (Jan. 1. 2009).

[35] Centers for Medicare & Medicaid Services, Medicare Advantage and Prescription Drug Benefit Programs: Negotiated Pricing and Remaining Revisions, 74 Fed. Reg. 1493, 1512 (Jan. 1. 2009).

[36] Centers for Medicare & Medicaid Services, Medicare Advantage and Prescription Drug Benefit Programs: Negotiated Pricing and Remaining Revisions, 74 Fed. Reg. 1493, 1512 (Jan. 1. 2009).

[37] Proposed Rule, 87 Fed. Reg. 79452, 79611.

> out in the calculation of costs eligible for Part D reinsurance consistent with the plain language of the statute, which requires that the reinsurance payment amount be based on net drug costs. While the use of the phrase in the current regulatory definition of GCPDC is consistent with the statute for this reason, we recognize that that it may have led to ambiguity as to when the DIR would be netted out. We also recognize that the use of the phrase could create ambiguity when GCPDC is referenced outside of the reinsurance context (as it now is by the IRA).[38]

As a result, CMS believes, it is necessary to remove the two references to "actually paid" from the regulatory provision implementing the statutory definition, "to clarify that GCPDC are not net of all DIR."[39] CMS emphasizes, however, that the change

> would have no impact on Part D payment calculations or reporting requirements. Consistent with section 1860D-15(b)(2), the reinsurance payment amount would continue to be calculated based on drug costs net of DIR.[40]

CMS further noted that, because of a new definition of ""negotiated price" effective January 1, 2024, all price concessions from network pharmacies will continue to be reflected in the negotiated price which is reflected in the gross covered prescription drug cost.[41]

CMS does not appear to be proposing to remove or amend the regulatory definition of "actually paid" from the CFR, so the phrase continues to have meaning.

II. Analysis

We have been asked if the IRA requires CMS to change its long-standing regulatory definition of gross covered prescription drug cost to remove "actually paid." In short, we believe the answer is no, the IRA does not require CMS to change its definition of gross covered prescription drug costs.

A. Text of the IRA does not require CMS to reinterpret gross covered prescription drug costs

In establishing the Drug Price Negotiation Program in the IRA, Congress defined "total expenditures" in relation to the gross covered prescription drug cost statutory definition. Specifically, for purposes of the Negotiation Program, total expenditures includes total gross covered prescription drug costs (with an exception for certain bundled, Part B drugs).[42] The IRA

---

[38] Proposed Rule, 87 Fed. Reg. 79452, 79611.

[39] Proposed Rule, 87 Fed. Reg. 79452, 79612.

[40] Proposed Rule, 87 Fed. Reg. 79452, 79612.

[41] Proposed Rule, 87 Fed. Reg. 79452, 79612.

[42] 42 USC § 1320f(c)(5) ("The term "total expenditures" includes, in the case of expenditures with respect to part D of subchapter XVIII, the total gross covered prescription drug costs (as defined in section [1860D-15(b)(3)] 1395w-115(b)(3) of this title). The term "total expenditures" excludes, in the case of expenditures with respect to part B of such subchapter, expenditures for a drug or biological product that are bundled or packaged into the payment for another service.)

also amended the Part D drug subsidy program and, in that amendment, referenced total gross covered prescription drug costs. In the Manufacturer Discount Program established in the IRA, Congress also cross-referenced total gross covered prescription drug costs when defining total expenditures (with the same definition as under the Negotiation Program).[43]

Thus, Congress clearly referenced the definition of gross covered prescription drug costs multiple times. These cross-references did not, however, require CMS to change its current interpretation of the gross covered prescription drug costs term. If Congress had intended for CMS to change its interpretation, it could have and it had multiple opportunities to do just that. In fact, Congress did clearly limit the definition of "total expenditures" in the Negotiation Program to "gross covered prescription drug costs" *excluding* certain bundled drugs, demonstrating that Congress understood the term that it cross-referenced and chose to modify it for Negotiation Program purposes.[44] Despite this, Congress did not modify CMS' gross covered prescription drug costs definition to exclude "actually paid" costs.

B. Congress legislates against the background of current interpretation

CMS has interpreted gross covered prescription drug cost to include "actually paid" since 2005. Importantly, "where, as here, Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the interpretation given to the incorporated law, at least insofar as it affects the new statute."[45]

Here, of course, Congress is cross-referencing a definition, but that definition is thus incorporated into the new programs Congress created in the IRA. It is reasonable to conclude that, because CMS has interpreted the definition consistently for nearly 20 years, Congress "had knowledge of the interpretation" of the definition. Moreover, for purposes of the new program, as explained above, Congress was careful to exclude certain bundled drugs from "total expenditures," which is otherwise the total gross covered prescription drug cost, ensuring that the new Negotiation Program operates as Congress intends. Absent affirmative direction from Congress, it is reasonable to conclude that Congress was aware of CMS' established definition and did not intend, via a cross-reference, to suggest to CMS it must change its longstanding interpretation of gross covered prescription drug cost to include "actually paid" costs.

C. Congress actually amended this provision without changing the definition

CMS first included "actually paid" in the regulatory definition of gross covered prescription drug costs in the fall of 2005. Congress has, since that time, amended the Part D program generally, and section 1860D-15 (the statutory section with the "gross covered prescription drug cost"

---

[43] 42 USC § 1395w-114c(g)(4)(D).

[44] The IRA's definition of "total expenditures" for purposes of the Drug Price Negotiation Program is the "total gross covered prescription drug costs" as defined in Part D, but "excludes, in the case of expenditures with respect to part B [of the Medicare title], expenditures for a drug or biological product that are bundled or packaged into the payment for another service." 42 U.S.C. § 1320f(c)(5).

[45] *Lorillard v. Pons*, 434 U.S. 575, 581 (1978).

definition) specifically, and has not changed CMS' definition or otherwise suggested that CMS' interpretation was incorrect.[46]

Perhaps most important for these purposes, Congress also actually amended the definition of "gross covered prescription drug costs" *in the IRA* to provide that, with respect to "applicable drugs" (which are generally those not selected by HHS for negotiation) costs include those paid by a manufacturer. This suggests that, at a minimum, Congress considered how the term "gross covered prescription drug costs" would need to be modified for purposes of the drug subsidy pro in light of the relevant new IRA programs. Nonetheless, Congress did not amend the applicable language to require that gross covered prescription drug costs not be interpreted to reflect "actually paid" costs.

Courts will at times place significant, even dispositive, weight on the fact that Congress has amended a provision.[47] Similarly, courts have also at times concluded that Congress adopts a settled interpretation when it reenacts a statute that had been consistently interpreted.[48] As the Supreme Court explained

> Congress is presumed to be aware of an administrative or judicial interpretation of a statute and to adopt that interpretation when it reenacts a statute without change.[49]

In this case, Congress actually made a change to the very definition at issue, but did not correct, modify or in any way suggest that CMS' long-standing definition of the provision was improper.[50]

---

[46] *See* I.B.1 and note 15, above.

[47] *Stone v. INS*, 514 U.S. 386, 397 (1995) ("When Congress acts to amend a statute, we presume it intends its amendment to have real and substantial effect."); *Pierce Cnty., Wash. v. Guillen*, 537 U.S. 129, 145 (2003)(rejecting a reading of a statute that would render an amendment an "exercise in futility.").

[48] *Lorillard v. Pons*, 434 U.S. 575, 581 (1978); *see also, Pierce v. Underwood*, 487 U.S. 552, 567 (1988)(in "a situation in which Congress reenacted a statute that had in fact been given a consistent judicial interpretation … [s]uch a reenactment, of course, generally includes the settled judicial interpretation."); *Bragdon v. Abbott*, 524 U.S. 624, 645 (1998) ("When administrative and judicial interpretations have settled the meaning of an existing statutory provision, repetition of the same language in a new statute indicates, as a general matter, the intent to incorporate its administrative and judicial interpretations as well.").

[49] *Merrill Lynch, Pierce, Fenner & Smith v. Curran*, 456 U.S. 353, 382 n.66 (1982)(concluding that when Congress re-examines and leaves a statutory provision intact that had been substantively interpreted by courts, it does so intentionally)

> "Congress is presumed to be aware of an administrative or judicial interpretation of a statute and to adopt that interpretation when it re-enacts a statute without change, see *Albemarle Paper Co. v. Moody*, 422 U.S. 405, 414, n. 8, 95 S.Ct. 2362, 2370, n. 8, 45 L.Ed.2d 280 (1975); *NLRB v. Gullett Gin Co.*, 340 U.S. 361, 366, 71 S.Ct. 337, 340, 95 L.Ed. 337 (1951); *National Lead Co. v. United States*, 252 U.S. 140, 147, 40 S.Ct. 237, 239, 64 L.Ed. 496 (1920); 2A C. Sands, Sutherland on Statutory Construction § 49.09 and cases cited (4th ed. 1973). So too, where, as here, Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the interpretation given to the incorporated law, at least insofar as it affects the new statute." *Lorillard v. Pons*, 434 U.S. 575, 580–581, 98 S.Ct. 866, 869–871, 55 L.Ed.2d 40 (1978).

[50] As the First Circuit concluded, when one statute was amended, but another related statute was not, "subsequent Congressional inaction may signal acquiescence to an agency interpretation." *Com. of Mass. v. Sec'y of Health & Hum. Servs.*, 899 F.2d 53, 60 (1st Cir. 1990), cert. granted, judgment vacated sub nom. *Sullivan v. Massachusetts*, 500 U.S. 949 (1991), and abrogated by *Rust v. Sullivan*, 500 U.S. 173 (1991).

In other words, this is not a case of Congress simply failing to act to correct an interpretation. By amending the definition specifically to function properly in Part D (after the newly enacted Programs) and by clarifying the exclusion of bundled drugs as the definition is used in the newly created the Drug Negotiation Program, Congress clearly and intentionally reaffirmed the statutory definition, and by implication, its long-standing interpretation.

D. Agency authority to continue long-standing interpretation

HHS, and its division CMS, has general authority to issue "such regulations as may be necessary to carry out the administration of the insurance programs under" Medicare.[51] Courts "generally will defer to a permissible interpretation espoused by the agency entrusted with its implementation."[52] And "[o]f particular relevance is the agency's contemporaneous construction which 'we have allowed ... to carry the day against doubts that might exist from a reading of the bare words of a statute.'"[53] Here we have CMS' contemporaneous interpretation of gross covered prescription drug costs and that interpretation has been consistently maintained for nearly twenty years. This suggests that courts would be inclined to uphold the current definition of gross covered prescription drug costs, absent evidence that Congress rejected it (which we do not have).

In addition,

> "[t]he Supreme Court has made clear that courts must give heightened deference to [an agency's] interpretation of a 'complex and highly technical regulatory program' such as Medicare."[54]

Here, the gross covered prescription drug costs definition is not only an operative definition in Part D, but a definition applicable to the Part D reinsurance subsidy, a technical part of the complex Part D program. As CMS explained in the preamble to the 2024 Proposed Rule, CMS included "actually paid" in its regulatory definition of gross covered prescription drug costs to "to emphasize that DIR [direct and indirect remuneration] would be netted out in the calculation of costs eligible for Part D reinsurance as required by the statute."[55] In other words, CMS read the definition in the context of the reinsurance subsidy required under Part D and interpreted the term in harmony with the context, a perfectly supportable interpretation.[56] CMS notes that the

---

[51] Social Security Act § 1871(a)(1); 42 USC § 1395hh(a)(1).

[52] *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 414 (1993).

[53] *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 414 (1993).

[54] *Washington Reg'l Medicorp v. Burwell*, 813 F.3d 357, 362 (D.C. Cir. 2015)(quoting *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1229 (D.C.Cir.1994) which was in turn quoting *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512, 114 S.Ct. 2381, 129 L.Ed.2d 405 (1994)).).

[55] Proposed Rule, 87 Fed. Reg. 79452, 79611.

[56] *Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644, 666 (2007)("It is a 'fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall

current definition—which includes "actually paid"—"is consistent with the statute …".[57] Indeed, CMS believes that even absent the phrase "actually paid" in the definition of gross covered prescription drug costs, "GCPDC would continue to be reduced by POS [point-of-service] DIR reflected in negotiated prices."[58]

However, after the passage of the IRA, and its cross-references to the gross covered prescription drug costs definition, CMS now believes that its long-standing definition "could create ambiguity when GCPDC is referenced outside of the reinsurance context (as it now is by the IRA)."[59] Yet, as we have seen above, there was no indication by Congress that it believed the long-standing definition was ambiguous, could cause any ambiguity in the new programs, or even that CMS' established interpretation of the statutory term should be revised simply because newly created programs now cross-reference it.

In short, CMS' contemporaneous interpretation of gross covered prescription drug costs was justifiable at the time it was issued and there is no evidence that Congress either objected to CMS' definition or that, in cross-referencing the term in the IRA, that Congress intended CMS to change its long-standing definition.

III. Conclusion

We believe the answer to the question of whether CMS is required by the IRA to amend its definition of "gross covered prescription drug costs" to remove the phrase "actually paid" is no. As explained above, the text of the IRA does not direct CMS to change its definition, and it is reasonable to conclude that Congress was aware of, and accepted, CMS' established definition of gross covered prescription drug costs, including the phrase "actually paid," when it cross-referenced the definition for purposes of the new programs. Moreover, Congress actually amended the definition at issue in the IRA to accommodate the newly created programs that cross-reference the definition and did not at that time "correct" CMS' interpretation. As a result, we do not believe that the IRA requires CMS to change its long-standing definition of gross covered prescription drug costs.

---

statutory scheme.' ") This is also supported by the fact that this is a long-standing interpretation that Congress has not felt it needed to change.

[57] Proposed Rule, 87 Fed. Reg. 79452, 79611.

[58] Proposed Rule, 87 Fed. Reg. 79452, 79612.

[59] Proposed Rule, 87 Fed. Reg. 79452, 79611.

TAB 17

As of: March 04, 2024
Received: February 13, 2023
Status: Posted
Posted: February 17, 2023
Category: Other - OT001
Tracking No. le3-bwt9-yw8j
Comments Due: February 13, 2023
Submission Type: Web

PUBLIC SUBMISSION

Docket: CMS-2022-0191
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024

Comment On: CMS-2022-0191-0001
Medicare Program: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, etc.

Document: CMS-2022-0191-0740
Comment on CMS-2022-0191-0001

Submitter Information

Email: danielle.horne@elevancehealth.com
Organization: Elevance Health

General Comment

Elevance Health appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') "Contract Year 2024 Policy and Technical Changes to the Medicare Advantage (MA) Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications," proposed rule, published on December 27, 2022. Please see our attached comments.

Attachments

Elevance Health Comments_2024 MAPD Proposed Rule(2023-02-13)

Submitted via Federal e-Rulemaking Portal: http://www.regulations.gov

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

February 13, 2023

Re: Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

Administrator Brooks-LaSure,

Elevance Health appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') "Contract Year 2024 Policy and Technical Changes to the Medicare Advantage (MA) Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications," proposed rule, published on December 27, 2022.

Elevance Health is a lifetime, trusted health partner fueled by its purpose to improve the health of humanity. We support consumers, families, and communities across the entire care journey – connecting them to the care, support, and resources they need to lead healthier lives. Elevance Health's companies serve approximately 119 million people through a diverse portfolio of industry-leading medical, digital, pharmacy, behavioral, clinical, and complex care solutions. Elevance Health serves over 2.5 million Medicare beneficiaries through our MA plans, nearly 1.5 million of the beneficiaries we serve are in MA-Part D (MA-PD) plans, and about 600,000 beneficiaries are full or partial-benefit dual eligibles.

Executive Summary

With the continued growth of the Medicare program and the success and popularity of MA and Part D, we urge CMS to implement policies that support the overall stability of the programs to enable plans to continue providing access to the affordable, high-quality care beneficiaries want and rely upon every day. We urge CMS to reconsider the magnitude of the

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

changes they have proposed across recent regulatory and sub-regulatory actions. When combined, they will result in significant disruption to the program and, more importantly, these changes will negatively impact nearly 50% of Medicare beneficiaries.

Nearly half of Medicare beneficiaries choose MA because it delivers better services, better access to care, and better health outcomes.[1] The value MA plans deliver to beneficiaries include out-of-pocket spending protections, reductions in cost-sharing and Part B premiums, access to prescription drug benefits – often at no additional cost, and important supplemental benefits like dental, vision, hearing, transportation, nutrition, and in-home support services. The value-based MA model outperforms Fee-For-Service (FFS) Medicare on clinical quality measures, improves survival rates, and reduces hospital readmissions.[2] [3] [4] Beneficiaries are also overwhelmingly satisfied with the MA and Part D programs as evidenced by surveys where 90% of respondents were satisfied with their coverage and would recommend MA to their friends and family.[5]

Below are: (1) Elevance Health's recommendations on key issues at a high level; (2) key issues we would highlight as CMS considers policies to implement the Inflation Reduction Act (IRA); and (3) detailed comments and recommendations.

Star Ratings

The MA Star Rating system was created by CMS in 2007 to measure MA and Part D performance based on specific measures on a 1 to 5 scale.[6] The system incentivizes quality improvement and public accountability and provides beneficiaries with a valuable tool to assist in choosing a high-quality health plan. A comparable comprehensive quality measurement system does not exist in FFS Medicare.

The Star Rating system continues to increase the quality of the health plans available, and the care provided to MA and Part D beneficiaries.[7] A robust body of research has shown that

[1] https://www.ajmc.com/view/quality-health-and-spending-in-medicare-advantage-and-traditional-medicare
[2] https://pubmed.ncbi.nlm.nih.gov/29130269/
[3] https://www.ajmc.com/view/value-based-contracting-innovated-medicare-advantage-healthcare-delivery-and-improved-survival
[4] https://pubmed.ncbi.nlm.nih.gov/29944655/
[5] https://www.affordableprescriptiondrugs.org/resources/americans-opinions-on-the-elimination-of-rebates-in-medicare-part-d.
[6] Sprague L.: *The Star Rating System and Medicare Advantage Plans*. Washington (DC): National Health Policy Forum; 2015 May 5. (Issue Brief, No. 854.): www.ncbi.nlm.nih.gov/books/NBK560455/
[7] O'Neill Hayes T: *Primer: The Medicare Advantage Star Rating System* (June 2015): www.americanactionforum.org/print/?url=https://www.americanactionforum.org/research/primer-the-medicare-advantage-star-rating-system

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

MA delivers significantly better care, leading to better outcomes and lower costs compared to FFS Medicare.[8] [9] [10]

Health plans with Star Ratings of at least 4-Stars receive bonus payments that must be used to offer additional benefits and lower cost-sharing for beneficiaries. We support improvements to the Star Rating system that appropriately incentivize high performance and quality improvement. However, we are concerned that taken together, the significant changes in the proposed rule would amount to a nearly $25 billion cut to the Star Ratings program. These cuts would lead to benefit cuts and cost increases for beneficiaries and undermine the Administration's health equity goals.

Eliminating the Hold Harmless for Star Rating Improvement Measures Would Negatively Impact Beneficiaries

We are concerned CMS' proposal to remove the hold harmless provision for the Star Rating improvement measures would harm beneficiaries by limiting the availability of high-quality plans and would lead to more out-of-pocket costs and access to fewer benefits for beneficiaries, impacting plans' ability to address social drivers of health. When CMS implemented the Quality Improvement (QI) measure, the agency acknowledged that the approach would create an unintended consequence: the QI measure for high-quality plans would drop once their ratings improved because—as plans improve their scores—it gets more difficult to produce a statistically-significant improvement year-over-year. In other words, a contract's Star Rating could drop due to a drop in the QI score, even if the plan continued to improve and make gains in each measure, but not enough to be statistically significant. Because of this unintended consequence, CMS implemented its existing hold harmless policy for plans who earn 4- and 4.5-Stars. This ensures a recognized high-quality health plan is not penalized for only making modest gains after reaching the 4-Star threshold. In turn, beneficiaries have more opportunities to enroll in high-quality contracts with at least 4 Stars and received additional benefits and reduced cost-sharing.

[8] DuGoff E, Tabak R, Diduch T, Garth V: Quality, Health, and Spending in Medicare Advantage and Traditional Medicare. The American Journal of Managed Care (September 2021): www.ajmc.com/view/quality-health-and-spending-in-medicare-advantage-and-traditional-medicare

[9] Timbie JW, Bogart A, Damberg CL, Elliott MN, Haas A, Gaillot SJ, et al.: Medicare Advantage and Fee-for-Service Performance on Clinical Quality and Patient Experience Measures: Comparisons from Three Large States. Health Services Research (December 2017): www.pubmed.ncbi.nlm.nih.gov/29130269/

[10] Mandal AK, Tagomori GK, Felix RV, Howell SC: Value-Based Contracting Innovated Medicare Advantage Healthcare Delivery and Improved Survival. The American Journal of Managed Care (February 2017): www.ajmc.com/view/value-based-contracting-innovated-medicare-advantage-healthcare-delivery-and-improved-survival

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Removing the QI Hold Harmless for 4- and 4.5-Star Ratings Devalues Quality Improvement

By proposing to change the hold harmless policy and only applying it to 5-Star plans, CMS would introduce the unintended consequence it originally sought to avoid. Plans that achieve 4- and 4.5-Stars and continue to make modest gains (but not enough to achieve 5-Stars) would see their QI measures score drop, despite continuing to be high-quality plans. This change would significantly decrease the number of contracts obtaining 4 or more Stars, increasing the volatility of Star Ratings, and reducing the incentive for quality improvement. The QI measures are intended to evaluate year-over-year improvement in contracts, not the number of measures that achieve 5-Stars as compared to other health plan contracts.

The Proposed Policy Would Lead to Lower Star Ratings Undermining Health Equity Goals

The existing hold harmless policy for the QI measures that apply to 4-Stars and above has driven quality improvement across measures. Achieving the 4-Star threshold increases the benchmark against which MA plans bid, and a portion of the savings between the bid and the benchmark are used to enhance benefit offerings and lower costs for beneficiaries.

The enhanced benefit offerings made possible by the current policy support work addressing health equity. Health plans that obtain the quality bonus payment for achieving 4-Stars or higher are able to offer more robust supplemental benefits such as dental, vision, and hearing coverage that improve whole-person health. Special Supplemental Benefits for the Chronically Ill (SSBCI) such as nutritious meals, transportation, and in-home supports go even further to help address social drivers of health.

By CMS' own estimate, the elimination of the hold harmless provision for 4- and 4.5-Star plans would result in over $19 billion in cuts over the next ten years, which are not mandated by Congress. A significant portion of these savings would come from supplemental benefits. Removing those benefits would directly harm the Administration's health equity goals. For these reasons, we urge CMS to withdraw this proposal.

Improve Health Equity Index (HEI) Reward Framework to Address Health Disparities

Elevance Health supports CMS' ongoing efforts to ensure the right incentives exist to promote the goal of addressing health disparities. We have implemented many strategies to improve

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

health equity, including working with a variety of stakeholders, such as community-based organizations, to provide innovative supplemental benefits like non-medical transportation, nutritious food, and home-safety services.

We agree that the existing reward factor should be improved to better gauge how measures can account for social risk factors in the Star Ratings program. However, CMS' proposal would drastically change the current reward factor so that it becomes a two-sided, net-zero, approach. We believe a system that focuses exclusively on rewards and is equitable for all plans to participate is the best approach.

CMS' proposal would create the following challenges:

- CMS proposes enrollment thresholds for the HEI reward that disqualify smaller contracts which would discourage the enrollment of beneficiaries with social risk factors in smaller tailored plans that best meet their needs, such Chronic Condition Special Needs Plans (C-SNPs);
- Create an incentive for contract enrollment gaming where health plans could target or avoid cohorts of beneficiaries, particularly dually eligible beneficiaries, and beneficiaries with chronic conditions, because CMS is not proposing any corrections (similar to risk adjustment) that would ensure contracts are fairly scored relative to the different populations in each contract, and its "net zero" approach would incentivize selection for the purpose of maximizing the HEI reward.; and,
- Undermine improvements in health equity in the majority of Group Retiree contracts. Group Retiree contracts will be too small to quality for the HEI reward, which directly impacts the resources available to address health-related social needs.

For these reasons, we recommend CMS withdraw this proposal and instead propose an improved framework that continues to take a reward-only approach (instead of a mix of rewards and penalties). If CMS moves forward with this proposal, we urge the agency to establish a transition period that phases-in the approach. The phase-in should ensure the revised approach is tested with data for at least three years, consistent with CMS' standard practice for display measures, plus one year considering the different Health Outcomes Survey (HOS) measurement years. CMS should ensure the current reward factor is still in place for three years, and then the revised approach could be phased-in during the following four years (for example, 25% in Y4, 50% in Y5, 75% in Y6, and 100% in Y7).

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Coverage Determinations and Prior Authorization

The application of health plan medical policy is one of the most effective ways to ensure the right care is provided at the right place and the right time. Experts have found that hundreds of billions of dollars are wasted every year in healthcare – and that beneficiaries often receive care that is costly, inappropriate, or unnecessary.[11] [12] Elevance Health's medical policies are developed by over 100 physicians and clinicians that have expertise in their specialties and are based on both peer-reviewed studies in medical literature and guidelines that reflect a strong clinical consensus among the medical specialty communities. By ensuring care is aligned with evidence-based medicine, Elevance Health drives towards improved health outcomes and reduced emergency department readmissions to align with CMS' strategic pillars to protect the Medicare program, drive innovation, and foster excellence.[13]

We appreciate CMS' efforts to ensure coverage determinations (including Utilization Management [UM] and Prior Authorization [PA]) are made using transparent medical policy and overseen by Medical Directors or other appropriate healthcare professionals with the appropriate experience. Focusing on these areas helps build beneficiary and provider trust in the market. To that end, Elevance Health supports CMS' proposals to require health plans to:

- Only use internal coverage criteria to the extent it is made publicly available;
- Involve Medical Directors or other appropriate healthcare professionals to ensure the clinical accuracy of medical necessity decisions where appropriate; and,
- Ensure staff reviewing coverage determinations have the appropriate expertise based on the item or service being requested.

Conforming MA Medical Policy to FFS Medicare would Undermine Health Outcomes and Increase Costs

CMS' proposal to require health plans to adopt the medical policy used by FFS Medicare fails to recognize that the application of FFS Medicare's medical policy may lead to worse health outcomes for beneficiaries and would have other negative implications. The FFS Medicare requirements are often incomplete, out of date, and do not contain the latest clinical

[11] Ricardo Alonso-Zaldivar: *Health-care system wastes $750 billion a year* (accessed January 2023): csmonitor.com
[12] Johns Hopkins Medicine: *Unneeded Medical Care is Common and Driven by Fear of Malpractice, Physician Survey Concludes* (accessed January 2023): hopkinsmedicine.org
[13] Centers for Medicare & Medicaid Services: *CMS Strategic Plan* (accessed January 2023): cms.gov

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

guidance from medical specialty communities. The shortcomings of FFS Medicare's medical policy include the following:

- **Lack of specificity in key areas:** FFS Medicare has a number of coverage policies that are vague and do not provide appropriate guidance, meaning the proposed regulation may have the practical impact of inhibiting any coverage denials in those areas, even in cases where the service being provided presents a safety risk.
- **Nonexistent medical policies in key areas:** In addition to those areas of medical policy that are vague, there are key benefit areas where FFS Medicare has no medical policy. While the proposed regulation would allow health plans to use their own medical policies in such circumstances, the rule appears to not allow guidelines built upon a clinical consensus that has not yet been incorporated into the published medical literature.

By proposing that MA plans conform their more up to date and complete coverage policies to FFS Medicare, CMS is working against a number of its stated goals to drive innovation and promote value-based, person-centered care in the following ways:

- **Worse health outcomes:** FFS Medicare coverage guidelines can be vague or fail to reflect the latest medical research in key areas; requiring health plans to adopt them would eliminate guidelines that are proven to improve health outcomes and reduce health risks for beneficiaries;
- **Reduced beneficiary choice:** Removing differentiation on coverage guidelines between health plans and FFS Medicare (and between health plans themselves) takes away an important element of beneficiary choice;
- **Lower value care:** Health plans work with providers on medical management policies to achieve better health outcomes and improvements in the Star Rating quality measures, affordability, and product design through value-based care arrangements; and,
- **Higher costs:** Health plan coverage guidelines are proven to help reduce costs; eliminating UM tools would increase costs to the Medicare program and result in higher premiums and/or reduced benefits.

CMS proposes to go even further than requiring health plans to conform to FFS Medicare guidelines by also proposing to prohibit the application of medical policies that requires one item/service to be furnished prior to another item/service. This proposal runs counter to one of the most important elements of medical policy: ensuring that a medical item or service is provided at the right time (that is, the right step in the course of treatment). Medical policy is often designed to ensure that a less invasive item/service is furnished prior to a more invasive

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

item/service, such as requiring an ultrasound prior to a Computed Tomography (CT) scan to limit unnecessary radiation exposure.

If CMS' proposals were finalized in this area, it would result in worse health outcomes, lower quality care, less beneficiary choice, and higher costs that would be passed on to beneficiaries in the form of higher premiums and/or fewer benefits, while exacerbating Medicare's financial challenges. For these reasons—and as explained in more detail below—we request CMS withdraw these proposals.

Medication Therapy Management (MTM) Eligibility Expansion

As a national MTM provider, Elevance Health has firsthand knowledge of how high-quality MTM services can make a difference in improving health outcomes, and we are supportive of finding opportunities to expand this service. However, instead of a thoughtful incremental expansion that would identify the beneficiaries most likely to benefit, CMS' proposed eligibility expansion would more than double those eligible for MTM services, diluting and devaluing the program for those who need it most and undermining the Administration's health equity goals.

Significant MTM Expansion Would Devalue MTM Services through Over-Expansion

As noted in the rule's preamble, the impact of implementing all the eligibility changes proposed would increase beneficiary eligibility from 4.5 million (9% of the Medicare population) to 11 million (23% of the Medicare population). Plan sponsors could not meet this substantial increase in volume overnight by simply scaling existing program elements. Due to pharmacy provider shortages, the strict administrative requirements of the program, and challenges engaging certain hard to reach beneficiary cohorts, without flexibility the proposal would undermine the effectiveness of the program for current beneficiaries.[14]

[14] National Community Pharmacists Association: *Survey: Three-Quarters of Community Pharmacies Report Staff Shortages* (accessed January 2023): ncps.org

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Undermining Health Equity Goals through Lower Star Ratings

Because Star Ratings help health plans provide supplemental benefits that address social drivers of health and support the Administration's health equity goals, it is important to consider how changes to the MTM program would impact Star Ratings. Elevance Health goes to great lengths to engage the existing MTM eligible population to maximize the Part D Comprehensive Medical Review (CMR) completion rate measure. Despite these significant efforts, we have difficulty reaching a percentage of existing eligible beneficiaries. Increasing the volume of MTM beneficiaries would result in even more difficulty achieving the 4- , 4.5-, or 5-Star Rating. Driving down Star Ratings would have the result of reducing the availability of supplemental benefits that help support health equity.

CMS Should Support Engagement of Currently Eligible Beneficiaries

We urge CMS to consider a different approach to expanding MTM services or, at a minimum, take a more incremental approach to the targeting criteria to ensure the potential expansion of this critical service is successful. We recommend CMS withdraw its existing proposal and provide more flexibility to help plan sponsors reach the beneficiaries who are already MTM eligible but not yet engaged. Specifically, we encourage CMS to move the new measure to display given the significant methodology changes and increase the chronic condition disease states incrementally by requiring plans to implement MTM for 6 chronic conditions versus 9. Withdrawing, or at a minimum delaying the significant proposed MTM expansion would allow plans to focus on the existing eligible population that has the greatest need, avoid diluting the program, and be more consistent with the Administration's health equity goals.

Payment Definitions: Gross Covered Prescription Drug Costs

CMS is proposing to change its definition of "Gross Covered Prescription Drug Costs" (GCPDC) to remove the phrase "actually paid." While CMS indicates in the rule's preamble that this proposed change intends to remove any ambiguity that may arise from the current definition, we are concerned it would have a significant, detrimental financial impact to the Medicare

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

program to the extent it flows into the selection of drugs for which CMS will negotiate prices pursuant to the IRA.

CMS Should Clarify Intent to Select Drugs for Negotiation Based on Costs Net of Rebates

If CMS finalizes this proposal, the agency could select drugs for negotiation irrespective of rebates, and thus, select drugs that would be duplicating the efforts of plan sponsors that already successfully negotiate with manufacturers. These negotiations reduce costs and offer more affordable and comprehensive prescription drug benefits to Part D beneficiaries. This in turn would lead to higher premiums, Medicare program costs, and taxpayer spending, which contradicts the intent of the IRA that is designed to produce savings, by targeting high-cost drugs lacking in any type of competition, including competition from other branded agents.

We recommend CMS withdraw this proposal and instead clarify that it intends to select drugs for negotiation based on costs net of rebates. Further, CMS should target single source drugs without any therapeutic competition, rather than only drugs without generic or biosimilar competition. Although often less discussed than generic-to-brand competitive dynamics, brand-to-brand competition can create leverage points for negotiations with manufacturers in the period before generics are able to enter a market. When therapeutic alternative drugs are available with the same efficacy, plan sponsors and their Pharmacy Benefit Managers (PBMs) are able to leverage this competition to negotiate price concessions from drug manufacturers, which results in lower costs for beneficiaries. Therefore, we urge CMS to refrain from selecting drugs with direct competitors—whether they are generics, brands, or biosimilars.

Marketing Requirements

Elevance Health strongly believes all MA and Part D marketing must be clear, accurate, and compliant with CMS regulations and sub-regulatory guidance. All marketing entities must meet standards to ensure beneficiaries are able to make the best healthcare choices that meet their needs. To best meet this objective, we have industry-leading processes in place that include not only ensuring our own materials and practices are compliant, but also monitoring the activities of contracted Third-Party Marketing Organizations (TPMOs).

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Marketing Accuracy is Important to Foster Trust in the Medicare Program

We support CMS' continued focus on closing marketing loopholes and targeting bad actors that mislead beneficiaries, cause abrasion, and reduce trust in the Medicare program. We appreciate policymakers' acknowledgement that a majority of the problems are not health plans or plan sponsors themselves, but rather a relatively small subset of third-party downstream entities and lead generators that may not have a direct contractual relationship with health plans.[15] Attempting to regulate TPMOs and other third parties through health plans results in the following challenges:

- TPMOs and other third parties typically market the plan options of a large number of health plans. Health plans may continue using marketing materials even when a single organization opts-out through the Health Plan Management System (HPMS) due to concerns that the activity does not meet all CMS requirements; and,
- Health plans cannot take collective actions against third-party bad actors due to antitrust constraints.

As bad actors may not have contracts with health plans or plan sponsors, CMS should have the appropriate regulatory authority and staffing to directly regulate those entities. We recommend CMS work with stakeholders and Congress to ensure the right framework exists to regulate third parties, which could include requiring all individuals/entities marketing MA and Part D to register with CMS (and be subject to direct audits and fines), along with fines for not being registered.

Within its existing authority, as explained in the detailed section of this letter, we recommend CMS take the following additional steps to mitigate non-compliant marketing of third parties:

- Preserve federal Medicare preemption to ensure consistency in addressing misleading marketing materials across the country;
- Create a consolidated document containing all marketing requirements with examples for stakeholders to reference since the regulatory requirements related to marketing are not published in one place today;
- Revise the process for TPMO material approval such that one lead health plan approves the final materials once to resolve edits quickly through a CMS review;

[15] U.S. Senate Committee on Finance: *Deceptive Marketing Practices Flourish in Medicare Advantage* (accessed January 2023): finance.senate.gov

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

- Establish a compliance resolution process for reports of potentially non-compliant marketing materials or tactics; and,
- Perform trainings targeted at TPMOs and downstream entities.

Several CMS Marketing Proposals Could Close Loopholes

Elevance Health appreciates CMS' efforts to close marketing loopholes to protect beneficiaries and make sure beneficiaries make the most informed coverage decisions. We are supportive of several of CMS' proposals with clarifications that:

- Prohibit TPMOs selling information to other TPMOs, while clarifying contact information can still be provided to an entity, including to health plans for follow-up;
- Modify the TPMO standard notice, while streamlining the language to avoid beneficiary confusion;
- Prohibit advertising that markets something as "savings" in a misleading way, with examples of scenarios and language that is appropriate;
- Require health plans to have an agent/broker monitoring and oversight plan, with an acknowledgement that health plans cannot monitor another organization real-time due to beneficiary privacy concerns;
- Establish required questions that must be asked prior to enrollment, with an appropriate number of streamlined questions;
- Extend the existing requirement to record calls, with flexibility if a beneficiary refuses to be recorded; and,
- Prohibit the use of superlatives without concurrent data backing up the claim.

Proposals Could Prevent Face-to-Face Sales and Exacerbate Health Inequity

CMS is proposing two significant changes that would have the effect of limiting face-to-face sales interactions: (1) a 48-hour wait time between a Scope of Appointment (SOA) being filled out and the appointment, and (2) separating sales events from educational events. Both of these changes would add additional burden, which would result in fewer face-to-face sales interactions overall.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Many of our sales are conducted through face-to-face interactions with beneficiaries, and we have found that a substantial portion of beneficiaries prefer face-to-face sales. Studies have similarly concluded that older adults strongly prefer in-person interactions and demonstrated that beneficiaries are most likely to enroll in the best plan that meets their needs following a face-to-face conversation.[16] [17]

For these reasons, as explained in more detail later in this letter, we urge CMS to withdraw the two proposals that would inhibit in-person sales conversations. Instead of prohibiting or inhibiting certain types of sales interactions, we urge CMS to instead focus on targeting the bad actors and closing marketing loopholes, irrespective of the type of sales interaction.

Exacerbating Health Inequity

While we have found that many Medicare beneficiaries prefer face-to-face interactions, the opportunity is especially critical for beneficiaries who are dually eligible for Medicaid and Medicare. In our experience, a larger share of dually eligible beneficiaries prefer face-to-face encounters given a lower level of access to technology. Undermining access to face-to-face sales would create more barriers for dually eligible beneficiaries (as compared to older adults earning higher incomes) to choose the best plan for them, undercutting efforts to improve health equity.

It is also important to consider the extra burden that each of these proposed rules would create for dually eligible beneficiaries seeking to have a face-to-face sales interaction. Instituting a 48-hour wait time between an SOA being filled out and the appointment would create a requirement for two in-person interactions. CMS' proposed change would require beneficiaries to gain additional access to transportation in a different location and devote additional time to have a second conversation, which can be challenging. Separating educational events from sales events would similarly be placing a heavy burden on beneficiaries to find additional time and transportation to have a second in-person sales interaction.

Expanding Gaps in Coverage

According to our internal data, 25% of beneficiaries wait until the last 7 days of open enrollment to have a sales conversation and enroll. Instituting a 48-hour wait time between an SOA being filled out and the appointment would essentially shorten the annual open

[16] Rivera-Hernandez M, Blackwood KL, Mercedes M, Moody KA: Seniors don't use Medicare.Gov: how do eligible beneficiaries obtain information about Medicare Advantage Plans in the United States?: BMC Health Services Research (February 2021): doi.org/10.1186/s12913-021-06135-7

[17] Shupei Y, Syed AH, Kayla DH, Shelia RC: What do they like? Communication preferences and patterns of older adults in the United States: The role of technology, Educational Gerontology, 42:3, 163-174, (2016): doi.org/10.1080/03601277.2015.1083392

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

enrollment period by two days. This creates a workload challenge with sales agents working to ensure those seeking to enroll at the last-minute do so with the best information possible. Many beneficiaries would not be aware of the mandated 48-hour waiting period, and if they fill out the SOA within the last few days of the enrollment period, they will likely not have an opportunity to enroll, creating a gap in coverage, undermining beneficiary access to care, care continuity, and satisfaction. This dynamic would also increase beneficiary complaints as additional abrasion would be created by the arbitrary 48-hour waiting period.

Increasing Disenrollments

Elevance Health is aligned with CMS' efforts to reduce disenrollments and ensure uninterrupted access to care. In our review of disenrollments by source of enrollment, we have found that those who enroll as part of face-to-face interactions exhibit the lowest proportion of disenrollments as compared to beneficiaries who enroll through other sources. The data demonstrate that—if a major goal is to decrease disenrollments—face-to-face interactions should be encouraged, not discouraged, as would be the effect of the proposed regulation.

Escalating Complaints

Elevance Health is aligned with CMS' efforts to limit and address beneficiary complaints to the largest extent possible. In our internal review comparing beneficiary complaints to source of enrollment, we found that beneficiary complaints are lowest among the cohort of beneficiaries that enrolls following a face-to-face sales interaction. This supports evidence in other areas that demonstrates beneficiaries receive the best information in face-to-face interactions, and those interactions should be encouraged instead of discouraged, as would be the case if these proposed provisions go into effect.

Mental Health (MH) and Network Adequacy

The U.S. is continuing to experience a dramatic increase in Mental Health and Substance Use Disorder (MH/SUD) needs in the wake of the COVID- 19 pandemic.[18] This persistent increase in demand has outpaced the supply of MH/SUD professionals. The Government Accountability Office's (GAO's) October 2022 report on the MH/SUD workforce in the U.S. in 2022 included the following conclusions:

- Approximately half of counties in the U.S. did not have an active psychiatrist or addiction medicine specialist;

[18] National Academies of Sciences, Engineering, and Medicine: Mental Health and Substance Use Disorders in the Era of COVID-19 - The Impact of the Pandemic on Communities of Color: Proceedings of a Workshop—in Brief. National Academies Press (March 2021): ncbi.nlm.nih.gov/books/NBK569170/ doi: 10.17226/26102

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

- More than 150 million people live in federally designated MH professional shortage areas; and,
- In the near future, the U.S. will be short between 14,280 and 31,109 MH/SUD providers.[19]

A recent report from the American Psychological Association reinforces the fact that demand for services exceeds the supply of MH professionals. Nearly half of 2,300 psychologists surveyed said they were unable to meet demand for treatment, while 60% have no more openings for new patients, and 42% have waitlists of at least 10 patients.[20]

- Given that a major challenge for all stakeholders is—foundationally—there are currently not enough MH/SUD providers in the U.S. As an alternative, Elevance Health supports policymaker efforts to increase the supply of MH/SUD providers over time to better meet increasing demand by: allowing peer support specialists to be eligible for Medicare reimbursement;
- Expanding the types of services and providers eligible to receive federal/state funds. For example, payment of asynchronous care, coaching, texting, and wellness services should be evaluated; and,
- Examining scope of practice/physician oversight/supervision rules to increase access to a broad array of providers and services.

Implement Policy Flexibilities Due to Shortage of MH/SUD Providers

Amid this shortage of MH/SUD providers, CMS is proposing to put more pressure on health plans by: (1) establishing network adequacy requirements for three types of MH/SUD providers, and (2) extending existing wait time standards to these services. These proposed requirements do not account for the foundational shortfall of MH/SUD providers and would not increase the supply of providers. If the standards cannot be met, beneficiaries would have fewer choices to the extent health plans are forced to reduce their footprint or avoid planned expansions. The proposals also could result in retaining low-quality providers in networks as health plans attempt to meet the new requirements, which would negatively impact beneficiary experience.

With respect to wait time standards, CMS does not have a reasonable and efficient framework for assessing appointment availability, and existing audits do not generate

[19] Government Accountability Office: Behavioral Health: *Available Workforce Information and Federal Actions to Help Recruit and Retain Providers* (October 2022): https://www.gao.gov/products/gao-23-105250
[20] American Psychological Association: *Psychologists Struggle to Meet Demand Amid Mental Health Crisis* (November 2022): apa.org/pubs/reports/practitioner/2022-covid-psychologist-workload.pdf

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

objective, consistent outcomes that would generate proof of compliance. This lack of a workable framework creates uncertainty for health plans, exacerbating the likelihood that health plans could curtail offerings, impacting beneficiary choice.

Health plans would also need time to collaborate with providers to develop a reporting system that allows health plans to collect appointment wait time data. The Fast Healthcare Interoperability Resource (FHIR) is the industry interoperability standard that allows health data, including clinical and administrative data, to be quickly and efficiently exchanged between entities. Currently, appointment scheduling information cannot be included in the FHIR record. Any attempt to implement new appointment wait time standards without a reporting system that is workable for both health plans and providers, including modifications to the FHIR standard so that appointment scheduling information can be included in the FHIR record, would lead to significant provider abrasion, discouraging provider participation in plan networks.

Because of these challenges and negative implications for beneficiaries, we recommend CMS:

- **Add flexibility to any new MH/SUD network adequacy standards:** We recommend CMS provide flexibility for any additional network adequacy justifications that would account for the fact that these standards would be new and implemented during a MH/SUD provider shortage;
- **Reconsider stringent wait time standards:** Wait times cannot be perfectly measured and are enforced using audits that do not generate perfect, objective results. Given the MH/SUD provider shortage, such audits would generate inconsistent results and needlessly increase administrative costs that would be passed on to beneficiaries. Instead, we encourage CMS to reconsider the wait time standards and work with stakeholders on accurately measuring and implementing such standards with appropriate flexibilities to avoid provider abrasion that could discourage participation with MA plans; and,
- **Help address the MH/SUD provider shortfall:** We request CMS work collaboratively with stakeholders to develop a comprehensive strategy to address the foundational shortfall of MH/SUD providers.

If CMS is intent on moving forward with new wait time standards, we request CMS delay the implementation of such standards until FHIR standards can be updated to help create a more efficient and effective way of demonstrating compliance.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

IRA Implementation

Incorporate Stakeholder Feedback and Work with Stakeholders to Educate Beneficiaries

Medicare Part D is a model of consumer choice and market competition that is improving access to prescription drugs and reducing out-of-pocket costs for more than 50 million beneficiaries.[21] Large scale changes such as Part D redesign in plan year 2025 will have broader program impacts given that that nearly 90% of beneficiaries are in MA-PD plans.[22] The Part D policy changes are expected to lead to reduced benefits, increased cost-sharing, and increased premiums for MA beneficiaries.

Given the significant volume of changes that will be implemented in the Part D program as a result of the IRA, it is critical that CMS continues to partner with plans and stakeholders to avoid issues with beneficiaries accessing medications and customer service challenges and ensure affordability and a positive beneficiary experience. Elevance Health is committed to working with CMS to implement the provisions within the IRA to ensure beneficiaries have uninterrupted access to their benefits. We appreciate CMS' acknowledgement of the need to work with stakeholders to ensure successful implementation of the law. Given the significant volume of changes that will be implemented in the Part D program, this collaboration will be critical to the operational success of any new requirements.

To that end, we have outlined our recommendations on key steps and questions CMS should consider to ease implementation challenges. We would like to work collaboratively with the agency to implement the significant changes to the Part D benefit required by the IRA. As CMS prepares to implement these changes, we recommend the agency:

- Collaborate with stakeholders to educate beneficiaries about the IRA changes and encourage CMS to display the latest information on www.CMS.gov and give health plans the option of adding links to health plan websites instead of requiring updates to model member materials;
- Defer enforcement on IRA-related complaints and audits through December 2023. This should apply to the Complaints Tracking Module (CTM), appeals and grievances, and Star Ratings given that the law was signed by President Joe Biden on August 16, 2022, after plan year 2023 bids were submitted on June 6, 2022, and implementation continues; and,

[21] https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment
[22] https://www.kff.org/medicare/issue-brief/medicare-advantage-2022-spotlight-first-look/

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

- To smooth the transition, we encourage CMS to provide a comment opportunity on proposed Part D risk adjustment model changes. Any potential changes to the risk adjustment model should be proposed with at least a 60-day comment period and 12 months in advance of the June bid deadline.

Given the volume of changes to Part D expected in the coming years, it is critical for plans and stakeholders to partner with CMS to educate beneficiaries, ensuring the delivery of robust benefits and quality care through the MA and Part D programs.

Detailed Comments

Star Ratings

The Star Rating system incentivizes quality improvement and public accountability and provides beneficiaries with a valuable tool to assist in choosing a high-quality health plan that best suits their personal needs and preferences. Any changes to the Star Rating system should not undermine the ability of health plans to deliver access to high-quality care to the millions of Medicare beneficiaries who rely on the program.

HEI Reward

Elevance Health supports CMS' ongoing efforts to ensure the right incentives exist to promote the goal of addressing health disparities in the Star Ratings system. Elevance Health has implemented many strategies to improve health equity and address health-related social needs, including working with a variety of stakeholders, such as community-based organizations, to expand access to non-medical transportation, nutritious foods, and accessible housing.

We agree that the existing reward factor could be improved to better gauge how measures can account for social risk factors in the Star Ratings system, and we believe a system that focuses exclusively on rewards (instead of a combination of rewards and penalties) is the best approach.

We are concerned that the proposal in its current form would undermine the Administration's health equity goals due to the significant negative consequences of the multiplier on health plan Star Ratings. CMS' proposal would drastically change the current reward factor so that it

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

becomes a two-sided, net-zero approach that looks at each measure and breaks contracts into thirds, with the top third of contracts receiving 1 point, the middle third of contracts receiving 0 points, and the bottom third of contracts receiving -1 point.

While we commend CMS for working to improve the reward factor, CMS' proposed revised framework would create the following perverse incentives and unintended consequences:

- **Working against health equity goals by lowering Star Ratings and reducing revenue available to help beneficiaries:** CMS' proposal to modify the HEI reward to be a two-sided approach would have the net impact of making it more difficult for plans to fairly receive the higher Star Ratings they have earned. These Ratings help generate the revenue for supplemental benefits—such as medically tailored meals, transportation, and in-home supports—that go even farther to address health-related social needs. CMS' penalties would reduce revenue for the plans that serve the beneficiaries who need these resources the most.
- **Discouraging enrollment of beneficiaries with social risk factors in C-SNPs:** C-SNPs are designed to provide targeted and tailored access to care and care coordination for beneficiaries with specific CMS-defined chronic conditions. Because CMS proposes enrollment thresholds for the HEI reward that disqualify smaller contracts, the proposed revisions would create an incentive for health plans to enroll certain beneficiaries in larger non-SNP contracts, who would be best served by the tailored care coordination available in SNPs.
- **Undermining improvements in health equity in majority of Group Retiree contracts:** As detailed above, under the proposed enrollment thresholds for beneficiaries with social risk factors, some contracts would not have access to the HEI reward, even if they are advancing health equity. By potentially rendering these contracts as ineligible for the reward, it would be more difficult for these contracts to achieve high Star Ratings. Any revisions to the HEI reward framework should ensure Group Retiree contracts qualify to ensure plans that are improving health equity can appropriately achieve high Star Ratings.[23]
- **Creating an incentive for beneficiary selection:** CMS has worked to mitigate any incentive for health plans to target or avoid cohorts of beneficiaries in its contracts. CMS' proposed "net zero" approach would incentivize selection for the purpose of maximizing the HEI reward, which would work against CMS' goal of eliminating incentives to enroll specific cohorts of beneficiaries in the risk adjustment program.

[23] https://repositorio.uc.cl/xmlui/bitstream/handle/11534/47031/Precarious%20Employment.pdf

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Recommendation: Elevance Health recommends CMS implement an HEI reward framework that exclusively rewards health plans for improving health outcomes of historically marginalized populations. Such an approach would mitigate the unintended consequences previously detailed in this letter. Specifically, we recommend CMS implement an approach that applies to all contracts (that is, removes enrollment thresholds) and is not two-sided.

However, if CMS moves forward with the proposed approach, we request CMS:

- Establish a transition period that phases in the proposed approach. The phase-in should ensure the revised approach is tested with data for at least three years, consistent with CMS' standard practice for display measures, plus one year considering the different HOS measurement years. CMS should ensure the current reward factor is still in place for three years, and then the revised approach could be phased in during the following four years (e.g., 25% in Y4, 50% in Y5, 75% in Y6, and 100% in Y7); and,
- Provide additional data to health plans to improve readiness for the policy change should CMS proceed with the significant methodological change. For health plans to be able to model the proposed policy change, we encourage the release of additional baseline and national performance data to enable health plans to make more informed investments in quality and health equity improvements. Specifically, we request the following information for each health plan for Star years 2021, 2022, and 2023:
    - The blended Social Risk Factor (SRF) population of Low-Income Subsidy/Dual Eligible (LIS/DE) and Disabled by contract;
    - The top 3rd, bottom 3rd, and middle 3rd cut points for all measures;
    - Blended measure rates for SRF population by contract;
    - National performance rates;
    - National SRF population levels;
    - How rates will be determined for the two-year combined rates;
    - How beneficiaries in a health plan for one year will be handled;
    - How survey measures will be addressed and whether they will be blended given that LIS/DE stratification reports do not include calculated values for Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures;
    - How Healthcare Effectiveness Data and Information Set (HEDIS) hybrid measures will be addressed;
    - Clarity on which measures are included and why certain measures are removed from the calculation;

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

- Sample calculation models that show the calculation of the HEI and reward values; and,
- How the reliability scoring in the LIS/DE and Disabled stratification reports are determined and used, and which values represent the 0.7 reliability level.

Improvement Measure Hold Harmless

Elevance Health is concerned about CMS' proposal to apply the hold harmless policy to the Health Plan and Drug Plan QI measure to contracts with only 5-Stars beginning with the 2026 Star Ratings, instead of contracts with 4-Stars and above. CMS' proposal would lead to billions in cuts from the MA program, directly impacting older adults and people with disabilities and which would undermine the Administration's health equity goals.

Undermining the Incentive to Improve Star Ratings and Devaluing the QI Measure

CMS has stated the goals of the Parts C and D Star Ratings are to drive quality improvement for plans and providers and empower beneficiaries or their caregivers to make healthcare decisions that best suit each individual's personal needs and preferences.[24] [25] [26] [27] CMS implemented the QI measure to create an extra incentive for health plans to improve measure scores, supporting increased access to high-quality health plans. Each measure is evaluated to determine if there was a statistically significant improvement year-over-year, and those scores are added together to create the QI score.

As the QI measure was implemented, CMS acknowledged that the approach would create an unintended consequence: the QI measure for high-quality plans would drop once their ratings improved because—as plans improve their scores—it gets more difficult to produce a statistically-significant improvement year-over-year. In other words, a contract's Star Rating could drop due to a drop in the QI score, even if the plan continued to improve and make gains in each measure, but not enough to be statistically significant.

[24] https://public-inspection.federalregister.gov/2022-26956.pdf
[25] https://www.cms.gov/newsroom/news-alert/cms-releases-2023-medicare-advantage-and-part-d-star-ratings-help-people-medicare-compare-plans#:~:text=Plans%20are%20rated%20on%20a,Part%20D%20prescription%20drug%20plans.
[26] https://www.cms.gov/Medicare/Health-Plans/Medicare-Advantage-Quality-Improvement-Program/Downloads/Quality_Strategy_061212.pdf
[27] https://www.cms.gov/newsroom/press-releases/medicare-announces-quality-bonus-payment-demonstration-medicare-health-plans

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Because of this unintended consequence, CMS implemented its existing hold harmless policy for plans with 4-Stars or above. This ensures a recognized high-quality health plan is not penalized for only making modest gains after reaching the 4-Star threshold.

CMS has acknowledged that plans reaching 4, 4.5, and 5-Stars offer high-quality access to healthcare, supports, and services. According to a CMS press release on 2023 Star Ratings, "[a]pproximately 72% of people currently in Medicare Advantage plans that offer prescription drug coverage are enrolled in a plan that earned four or more stars in 2023. Approximately 51% of Medicare Advantage plans that offer prescription drug coverage will have an overall rating of four stars or higher in 2023."[28] CMS highlighting this data indicates that the agency believes 4-Star performance or higher is above-average level and should not be penalized.

This proposed change would significantly increase the volatility of the Star Ratings and undercut the incentive for improvement. In the Star Ratings system, we expect that health plans with higher Star Ratings will have more 5-Star measure ratings, with fluctuations based upon the calculation of cut points as a byproduct of overall industry performance. This enables even 5-Star contracts to improve. The QI measures are intended to evaluate year-over-year improvement in contracts measure scores, not the number of measures that achieve 5-Stars as compared to other contracts.

Undermining Health Equity Goals

As outlined above, the existing hold harmless policy for the QI measure that applies to 4-Stars and above has created the right incentive to drive quality improvement across measures. Those 4-Star and 4.5-Star plans can continue to make modest gains and not be penalized for continually improving scores year-over-year. Achieving the 4-Star threshold increases the benchmark against which an MA plan bids, and a portion of the savings between the bid and the benchmark is used to enhance benefit offerings and lower costs for beneficiaries.

The enhanced benefit offerings made possible under the existing hold harmless approach is contributing to advancing health equity, in support of the Administration's goals. Traditional supplemental benefits such as dental and vision coverage address whole health needs. Additional supplemental benefits such as medically tailored meals, transportation, and in-home supports go even farther to address health-related social needs.

According to CMS' own estimate, the elimination of the hold harmless provision for 4-Star and 4.5-Star plans would result in over $19 billion in cuts over the next ten years.[29] A significant

[28] https://www.cms.gov/newsroom/news-alert/cms-releases-2023-medicare-advantage-and-part-d-star-ratings-help-people-medicare-compare-plans
[29] https://public-inspection.federalregister.gov/2022-26956.pdf

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

portion of these savings would come from the elimination of supplemental benefits being provided to historically marginalized populations, including dental, vision, nutritious food, transportation, and in-home supports.

Recommendation: Elevance Health urges CMS to maintain the current improvement measure hold harmless provision for contracts with 4-Stars and above. Any changes to the Star Ratings should improve the long-term stability of the MA program and avoid undermining the ability of MA plans to deliver access to high-quality care to millions of older adults and people with disabilities. The CMS proposal would lower the incentive for health plans to make quality-improvement investments and would result in fewer rebate dollars available for supplemental benefits that address social drivers of health such as transportation, nutritious food delivery, and in-home services and supports, compounding disparities in health outcomes.[30] [31]

Quality Bonus Payment Rules

CMS is proposing to prohibit MA organizations from appealing measures that are based on feedback or surveys that come directly from plan beneficiaries. The survey data collected for CAHPS and HOS measures are subjective, and the collection methods for these surveys may result in bias due to the diverse beneficiary responses and differences in survey and digital literacy across member populations. We encourage CMS to allow MA organizations to retain the right to raise methodological questions about the accuracy of survey measure scores given that the measures are case mix adjusted, the potential for incorrect adjustments, and invalid responses from beneficiaries.

Additionally, we encourage CMS to increase transparency around the underlying calculations at a contract-level for CAHPS. We are concerned the additional calculations CMS performs for CAPHS measures do not undergo external audit, and unlike the HEDIS measures, these measures are not generated from a certified rules engine.

Recommendation: We ask CMS to continue to allow MA organizations to appeal survey measure scores in the calculation of the quality bonus payments given that the measures are case mix adjusted, the potential for incorrect adjustments, and invalid responses from beneficiaries.

[30] JAMA. "Patient Characteristics Associated with Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic." December 2020. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774488.
[31] AJMC. "Differences in the Use of Telephone and Video Telemedicine Visits During the COVID-19 Pandemic." January 14, 2021. http://tinyurl.com/2or2482g.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

We also encourage CMS to increase transparency around the underlying calculations at a contract-level for CAHPS, which may help avoid such appeals of survey measure scores in the calculation of the quality bonus payments.

Removal of Star Ratings Measures through Sub-Regulatory Guidance

CMS proposes to allow for removal of Star Ratings through sub-regulatory guidance if a third-party steward (for example, National Committee for Quality Assurance [NCQA]) retires the measure.

Recommendation: Elevance Health supports this proposal. To support increased transparency, we also recommend CMS:

- Maintain a chart on its website that shows which measures are being scored in which years and each measure's associated weight in scoring. This would reduce administrative costs across the MA program, as all health plans currently need to maintain and track which measures are scored in which year; and,
- Provide a table in each proposed and final rule that includes the measure being added/retained/removed for each rating year, each measure's weight, if the measure will be scored or simply included for display-only, and footnotes to indicate if the measure is endorsed by a consensus-based entity (such as the National Quality Forum [NQF]) or was recently added/removed from the Star Ratings.

Consumer Experience, Complaints, and Access Measure

CMS proposes to reduce the weight of the patient experience/complaints and access measures by half (from a weight of 4 to 2) for the 2026 Star Ratings (which is the 2024 measurement period). Elevance Health appreciates CMS willingness to listen to concerns regarding the challenges associated with CAHPS surveys and outcomes that are not directly within the control of the health plan and not based on objective, clinical measures. Given the timing and resources invested in these measures, Elevance Health believes those elements directly within the control of the health plan should continue to be emphasized with the full weighting.

In CMS' proposed HEI, the agency states the focus of the measurement is on measures within the health plan's control – for example, the appeals and call center measures focus on the

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

plan and its operations rather than on beneficiary perceptions. We support CMS drawing this distinction between measures with beneficiary-level information like the CAHPS survey data that is more subjective, and those that more objectively measure health plan actions.

For this reason, we support an alternative where patient experience/complaints and access measures are divided into two categories: (1) those which are out of the health plan's direct control, such as the CAHPS survey, which would be weighted as a 2; and (2) those related to beneficiary experiences and access to their health plan that are within the direct control of the health plan, which would be weighted at 4. This approach would better align the measure weights based on the extent to which the outcomes are within the control of the health plan.

Recommendation: Elevance Health recommends the consumer experience, complaints, and access measure set is divided into two categories starting in Star Ratings Year 2023: (1) CAHPS measures that are subjective survey questions that demonstrate the experience the beneficiary has with the provider [lower to 2-weight]; and (2) the measure elements that are related to health plan operations and access [maintain at the current 4-weight].

This approach would continue to hold health plans accountable with respect to elements that are directly in the health plans control while lowering the weight of the survey measures, which are more subjective, not directly within the control of the health plan and based more on the CAHPS which is flawed due to the decreasing response rates and the lack of objective clinical measures. Should CMS disagree with this approach, we encourage the agency to consider a compromise in which all of the consumer experience, complaints, and access measures are weighted as a 3.

Removing Star Rating Guardrails

CMS is proposing to remove guardrails when determining measure-specific thresholds (cut points) for non-CAHPS measures. Because CMS implemented the mean rescoring methodology for 2023 Star Ratings and intends to add the Tukey outlier deletion to the hierarchical clustering methodology beginning with the 2024 Star Ratings to improve the predictability and stability of cut points, CMS believes that guardrails are no longer needed. Under this proposal, guardrails for non-CAHPS measures would only be effective through the 2025 Star Ratings and not apply for the 2026 Star Ratings or later.

We oppose the removal of the guardrails. The guardrails policy provides known data elements prior to the performance year improving the overall predictability of cut points. Instead, we support the removal of the Tukey outlier deletion, which undermines the predictability of cut points. We have concerns with the implementation of the Tukey outlier

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

deletion process, and its impact on the calculation of cut points for Star Ratings as the process is executed after the measurement year has ended and all performance indicators have been reported. While Tukey fences are generally considered effective at detecting outliers, deletion of outlier data is a controversial practice particularly in instances where a normal distribution cannot be assumed. Normally this practice is used when outliers result in a data error, which is not an issue in the Star Rating measures given the data validation processes used to calculate final scores. We provide an analysis of our concerns with the Tukey outlier deletion in Appendix I of this letter.

We encourage CMS to put the Tukey outlier deletion policy on hold to further evaluate whether the policy is necessary if the guardrails remain in place. Should the agency move forward, we support a delay in the removal of the guardrails to provide CMS an opportunity to determine whether any unintended consequences materialize from the implementation of the Tukey outlier. We also emphasize the need for flexibility and exceptions in instances with unforeseen consequences, such as natural disasters or another pandemic. In these situations, it may be important to account for the volatility in cut points as these policies could have a negative impact on beneficiaries' access to high-quality plans.

Recommendation: Elevance Health requests CMS modify this proposal as follows:

- Maintain the guardrails, while removing the Tukey outlier deletion process to improve the predictability and stability of cut points;
- Should the agency move forward, we support a delay in the removal of the guardrails to provide CMS an opportunity to determine whether any unintended consequences materialize from the interaction of guardrail and Tukey outlier policies; and,
- Allow for flexibility in the event of significant unforeseen circumstances, such as natural disasters or another pandemic, where guardrails or exceptions may reduce potential volatility to improve beneficiaries access to high-quality health plans.

Weighting of Measures with a Substantive Specification Change

CMS proposes to clarify that when a measure with a substantive update moves back to Star Ratings from the display page following rulemaking, it is treated as a new measure for weighting purposes and therefore would receive a weight of 1 for its first year back in the Star Ratings program.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Recommendation: Elevance Health supports this change, as it would result in a phase-in and reduce potential volatility.

Recommendations to Improve the Star Ratings

Elevance Health appreciates CMS' willingness to take a collaborative approach on improving the Star Ratings. We have the following recommendations on ways to further improve the program to support high-quality plan options for beneficiaries:

- **Avoid significant year-over-year changes:** It can take years of focused efforts and investments to improve even one Star Rating measure. We encourage CMS to look at Star Ratings changes in aggregate and avoid significant disruptions that undermine the system, and beneficiary access to supplemental benefits and reduced cost-sharing.
- **Provide advance warning when measures are likely to change:** While CMS often provides updates and comment opportunities when it is considering changing some measures, we encourage increased communication and transparency from CMS on future actions and goals for the Star Rating system. For example, we have seen proposed changes on pharmacy-related measures (such as this year), where the industry had minimal warning. If the industry has advance warning, health plans can start making investments to reach CMS' updated objectives more quickly and efficiently to support beneficiary access to healthcare, supports, and services.
- **Increase the reliability of survey data:** Elevance Health supports CMS' interest in increasing response rates for the MA and Prescription Drug Plan (PDP) CAHPS surveys as well as potential new questions. We would like to collaborate with CMS and measure stewards like the Agency for Healthcare Research and Quality (AHRQ) and NCQA to update and improve the survey to ensure it provides an accurate portrayal of the beneficiaries' experience and considers the evolving healthcare system, health equity and the diversity of the MA population, and the growing use of technology resulting from the COVID-19 pandemic.

Part D Proposed Changes

MTM Eligibility Expansion

CMS proposes several changes that would substantially expand the program, including:

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

- Requiring Part D plan sponsors to include all core chronic diseases when identifying beneficiaries who have multiple chronic disease (from 5 to 9) and adding HIV/AIDS to the list;
- Decreasing the maximum number of Part D drugs that a Part D plan sponsor may require from 8 to 5;
- Defining maintenance drugs (for targeting criteria) such that the Part D plan sponsors would no longer be allowed to target only specific Part D drug classes, but would be required to target all Part D maintenance drugs; and,
- Lowering the cost threshold to the average annual cost of 5 generic drugs.

The MTM program currently targets and is tailored to beneficiaries who would benefit the most from support. We are concerned the proposed changes would dilute this targeted approach. Instead, we urge CMS to work with Part D plan sponsors and stakeholders to ensure the beneficiaries who would benefit the most from MTM services are successfully engaged in the program.

Diluting and Devaluing MTM Services through Over-Expansion

We commend CMS for continuing to focus on the MTM program and the agency's focus on health equity. As a national MTM provider, we have firsthand knowledge and experience with how high-quality MTM services can make a difference in supporting beneficiaries and improving health outcomes. Beneficiaries may benefit from a letter intervention to improve medication adherence if they cannot be reached by phone, but the efficacy of the program across the newly proposed chronic conditions is largely unproven.[32] While we support appropriate expansions of the MTM program based on clinical evidence, this should be done in an incremental way to ensure its success for any new cohorts of beneficiaries while not diluting and devaluing the program for existing eligible beneficiaries.

In the proposed rule, CMS states the impact to implementing all the criteria changes would increase beneficiary eligibility from 4.5 million (9% of the Medicare population) to 11 million (23% of the Medicare population). Plan sponsors could not meet this substantial increase in volume by simply scaling existing program elements. There are currently provider shortages, and the expansion would place additional stress on pharmacists able to conduct MTM CMRs. Such a rapid expansion could lead to lower-value MTM programs that undermine investments in the more targeted care management programs currently in place.

[32] https://www.pharmacytimes.com/view/cost-effectiveness-of-medication-therapy-management-in-part-d-diabetic-enrollees

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Undermining Health Equity Goals through Lower Star Ratings

Given that Star Ratings help high-quality health plans provide supplemental benefits that support health equity, it is important to consider how changes to the MTM program will impact the Part D MTM CMR Completion Rate measure. Despite significant outreach efforts, health plans have difficulty reaching a percentage of existing eligible beneficiaries. Given the ongoing challenges with higher measure-level cut points to obtain a 4-, 4.5, or 5-Star Rating, and the guardrails policy that could interact with this proposal as detailed previously in this letter, increasing the volume of MTM eligible beneficiaries would result in even more difficulty achieving the 4-, 4.5-, or 5-Star Rating. Driving down Star Ratings would have the result of reducing the availability of supplemental benefits and lower costs for beneficiaries.

Recommendation: Elevance Health recommends CMS withdraw its proposal to expand MTM eligibility. We recommend the focus remains on beneficiaries who are currently eligible and most likely to benefit—but are not engaged—instead of expanding eligibility. Given the difficulty reaching certain cohorts of existing eligible beneficiaries despite significant effort, we recommend the following changes to improve the success rate of outreach:

- Relax the existing requirement that beneficiaries be reached within 59 days to allow for continued outreach; and,
- Allow CMRs to be completed via mail or email. We recognize this runs counter to CMS' proposal to codify the requirement for CMRs to be performed in real-time with the beneficiary, but for those beneficiaries who do not engage despite several attempts, a CMR being mailed and/or emailed may still allow a plan sponsor to connect with a beneficiary on their terms.

If CMS pursues the proposed MTM eligibility expansion, we recommend the agency:

- Take an incremental approach and delay implementation to enable stakeholders to prepare for implementation given the shortage of pharmacists. Specifically, CMS should move the new measure to display so that it is monitored in parallel with the existing measure to compare outcomes across all contracts; and,
- Increase the chronic condition disease states incrementally, by requiring plan sponsors to implement MTM for 6 chronic conditions versus 9 based on the groups the MTM program is best equipped to serve.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Payment Definitions: Gross Covered Prescription Drug Costs

CMS is proposing to change its definition of "Gross Covered Prescription Drug Costs" (GCPDC) to remove the phrase "actually paid." While CMS indicates in the preamble that this proposed change is to remove any ambiguity that may arise from the current definition, we are concerned it could have a significant, detrimental financial impact to the program, to the extent it flows into the selection of drugs for which CMS will negotiate prices pursuant to the IRA. By removing the phrase "actually paid," CMS could be removing the impact of rebates, which have been found to lower Part D program costs.[33]

If CMS were to select drugs for negotiation irrespective of rebates, it could be selecting the wrong drugs and duplicate efforts of plan sponsors that already successfully negotiate with manufacturers. In addition, if gross, rather than net prices, will determine whether a drug is selected for negotiation under the IRA, manufacturers are unlikely to agree to rebates with Part D plans as those price concessions will not be accounted for when the federal government selects drugs for negotiation under the IRA. This would hamper Part D plans' ability to secure prices concessions, which in turn would lead to higher premiums, program costs, and taxpayer spending, which contradict the intent of the law that is designed to produce savings by targeting high-cost drugs lacking in any type of competition, including competition from other branded agents. We are particularly concerned about specific drug classes, including oncology, HIV, and anti-psychotics drugs, which have extremely high levels of aggregate spending and little willingness from manufacturers to negotiate price concessions. CMS should address high-drug expenditures within these classes.

Recommendation: Elevance Health recommends CMS withdraw this proposal and instead clarify that it intends to select drugs for negotiation based on costs net of rebates. Further, CMS should target single source drugs without any therapeutic competition, rather than only drugs without generic or biosimilar competition. Although often less discussed than generic-to-brand competitive dynamics, brand-to-brand competition can create leverage points for negotiations with manufacturers in the period before generics are able to enter a market. When therapeutic alternative drugs are available with the same efficacy, plan sponsors and their PBMs are able to leverage this competition to negotiate price concessions from drug manufacturers, which results in lower costs for patients. Therefore, we urge CMS to refrain from selecting drugs with direct competitors—whether they are generics, brands, or biosimilars.

[33] Medicare Part D: Use of Pharmacy Benefit Managers and Efforts to Manage Drug Expenditures and Utilization | U.S. GAO.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Overpayment Look-Back for Prescription Drug Event (PDE) and Direct and Indirect Renumeration (DIR)

Regarding the process used to recoup overpayments associated with PDE and DIR, CMS also proposes to modify the timeframe for a "reopening for good cause" from within four years to within six years.

While Elevance Health does not have a conceptual problem with expanding the timeframe for overpayments associated with PDE and DIR, we are concerned that looking back more than four years would result in administrative costs that exceed the value of the recoupments. We recommend CMS pursue an analysis to determine if this proposed change adds value to the program, in support of the Medicare Trust Fund.

Recommendation: Elevance Health recommends CMS withdraw this proposal unless an analysis demonstrates that the expanded timeframe would result in recoupments that exceed increased administrative costs.

De minimis Threshold for Refunds and Recoveries

Within its proposal on mid-year benefit changes, CMS proposes to establish a de minimis threshold for refunds and recoveries associated with incorrect collections of premiums and cost-sharing.
Elevance Health supports this proposal as we have found that exceedingly small refunds generate abrasion with beneficiaries and complaints asserting the plan sponsor is being wasteful.

Recommendation: Elevance Health recommends CMS finalize this proposal to limit administrative costs, creating savings that can be passed along to beneficiaries.

Shortages of Formulary Drug Products During a Plan Year

CMS proposes requiring Part D plan sponsors to permit beneficiaries affected by a drug shortage to obtain coverage for a therapeutically equivalent or interchangeable non-formulary alternative without requiring those beneficiaries to meet formulary exception requirements.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Recommendation: Elevance Health recommends CMS define "affected enrollee" for the purposes of formulary drug shortages as a beneficiary with a history of taking the drug within a minimum of 108 days. We encourage CMS to ensure this requirement does not apply to a beneficiary who presents a new prescription for the drug due to operational challenges. Currently, we have no way to proactively identify these beneficiaries, or direct them at the point-of-sale to a more affordable and therapeutically equivalent alternative. If this proposal applies to new starts, we would require additional time to implement the policy change and recommend it apply no earlier than the 2025 plan year.

Changes to an Approved Formulary

Clarify CMS Requirements Around Cost of Immediate Drug Substitutions

CMS states that Section 11001 of the IRA allows the government to negotiate certain drug prices and requires that a drug for which a maximum fair price is in effect must be included on a plan's formulary. In § 423.120I(2)(i), CMS proposes to permit immediate substitutions, which would mean Part D sponsors could:

- Immediately make generic substitutions as well as substitute a new "interchangeable biological product" for its corresponding reference product;
- Substitute a new "unbranded biological product" for its corresponding brand name biological product; and,
- Substitute a new "authorized generic" for its corresponding brand name equivalent.

Given that the definition of maximum fair price is broad, we encourage CMS to provide health plans with the flexibility to determine the lowest price of the drug.

Recommendation: We encourage CMS to further clarify expectations for when a drug is removed from the formulary and give health plans the flexibility on a drug-by-drug basis, to determine the lowest price of the drug.

Enable Clinical Experts Outside of P&T Committee to Identify Appropriate Formulary Alternatives

CMS proposes changes to obtaining approval to make updates to a formulary already approved by CMS, and the requirements for providing notice of such updates. Specifically, for notice of negative immediate changes, we appreciate CMS removing the requirement that the alternative drugs must be in the same therapeutic category or class. However, we are concerned about the requirement that the Part D plan sponsor's Pharmacy and Therapeutics

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

(P&T) Committee must identify clinically appropriate formulary alternatives at the time the formulary change is being evaluated.

Elevance Health strongly encourages CMS to allow other qualified clinical experts from the health plan to identify appropriate formulary alternatives. We are concerned that putting the responsibility on the P&T Committee, which is only required to meet quarterly, would put health plans at risk of failing the meet CMS' 30-day beneficiary notification requirement for notices of maintenance and non-maintenance changes.

Recommendation: We encourage CMS to allow Part D clinical experts from the health plan to identify appropriate alternatives in the event of an update to an approved formulary. Putting the responsibility solely on the P&T Committee, which is only required to meet quarterly, would put health plans at risk of failing the meet CMS' 30-day beneficiary notification requirements.

Health Equity, Dual Eligibles, and SNPs

C-SNP Chronic Conditions

CMS proposes to expand the list of chronic conditions C-SNPs can target. This expansion would include additional condition categories and additional diseases within existing categories.

As a health plan that serves beneficiaries with chronic conditions through C-SNPs, Elevance Health greatly appreciates CMS' commitment to expanding eligibility for C-SNPs to include additional conditions. Our C-SNPs have helped improve health outcomes for beneficiaries, and we are eager to expand our tailored care to additional chronic conditions. We particularly appreciate opportunities to help additional beneficiaries with Chronic Kidney Disease, where the care coordination offered by C-SNPs would help beneficiaries better manage their disease and delay, or even avoid, progression to End-Stage Renal Disease.

Recommendation: We recommend CMS finalize the proposed expansion of chronic conditions in C-SNPs.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Additional Provider Directory Elements Related to Health Equity

Creating a National Provider Directory

Elevance Health shares CMS' commitment to ensuring provider directories meet the needs of all beneficiaries, particularly historically marginalized populations who may experience more barriers accessing the care they need. We also commend CMS for acknowledging that health plans do not have full control over their provider directories and are largely reliant upon providers to share accurate and timely information. Providers experience significant burden reporting information to all health plans with which they do business, and the response rate from providers to health plans about provider directories is low. Therefore, Elevance Health is supportive of CMS' effort to create a National Directory of Healthcare Providers and Services (NDH). Creating an NDH that acts as a single source of truth for provider directories is the most efficient way to ensure health plans have all information needed for accurate, comprehensive provider directories.

Recommendation: Elevance Health recommends CMS and stakeholders focus provider directory efforts on creating an NDH rather than establishing any new piecemeal requirements that would draw resources away from focusing on the NDH and would have limited value in the interim while creating additional provider abrasion.

Languages Spoken by Providers

CMS proposes provider directories include an element related to non-English languages spoken by the provider. Elevance Health supports CMS' efforts to ensure beneficiaries can easily identify providers who speak non-English languages. Given that CMS has already deemed this a best practice, in our provider directories, we already identify non-English languages spoken by providers (to the extent we are aware), and it is the first data element listed under the provider's name.

The biggest challenge associated with this proposed requirement is obtaining the information from the provider. We understand the value of providing this information to our Medicare beneficiaries; therefore, our current practice is to provide a list of languages providers speak in our directories. However, currently we are only able to provide languages for nearly 30% of our providers who have indicated they speak a non-English language.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Recommendation: Elevance Health recommends CMS delay this requirement and instead focus on obtaining the data from providers to support beneficiaries in making educated decisions about their healthcare:

- As detailed above, deploy an NDH that collects language information for providers on behalf of all health plans;
- Add a data element to the National Provider Identifier (NPI) for providers to indicate non-English languages that are spoken;
- Conduct a provider directory education campaign to encourage providers to respond to questions from health plans related to provider directories; and,
- Provide an audit safe harbor if a health plan can show a good faith effort to collect and list the languages a provider speaks in our directories, but the provider did not share that information.

Provider and Location Accessibility

CMS proposes to require provider directories include data elements related to provider and location accessibility for people with physical disabilities.

Elevance Health supports CMS' efforts to ensure provider and location accessibility. In our provider directories, we already identify providers with Americans with Disabilities Act (ADA) accessibility (to the extent providers share that information) for beneficiaries with physical disabilities. We work to list this information in our directories; however, currently only approximately 6% of our providers share ADA access information to help us populate our provider directories.

Recommendation: We have the following recommendations to improve health plan and provider data for inclusion in our directories:

- As detailed above, deploy an NDH that collects data elements on providers' ability to accommodate beneficiaries with disabilities;
- Add a data element to the NPI to capture providers' ability to accommodate beneficiaries with disabilities;
- Conduct a provider directory education campaign to encourage providers to respond to questions from health plans related to provider directories; and,
- Provide an audit safe harbor if a health plan can show a good faith effort to collect provider accessibility information for our directories, but the provider did not share that information.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Searchable by Every Data Element

CMS proposes to require a health plan's provider directory be searchable by every element. We currently work to ensure our directories are searchable by the data elements that are most useful for beneficiaries. For example, our directories are searchable by provider name, NPI, specialty type, and many more data elements can be filtered to narrow search results. However, there are certain data elements that would not be helpful to beneficiaries such as contract number or provider email address.

Recommendation: Elevance Health recommends CMS withdraw this proposal and instead propose a list of search elements that is prioritized based on elements beneficiaries currently use in their searches. Specifically, we would support prioritizing beneficiary preferences such as name, NPI, gender, provider specialty, procedure, provider type (for example, hospital, lab, etc.), telehealth availability, and location.

Materials in Alternative Languages and Auxiliary Aids

CMS proposes to require health plans to provide materials to beneficiaries on a standing basis in non-English languages and accessible formats upon receiving a request for the materials in that language/format. In the preamble, CMS notes this means that once a plan learns of a beneficiaries' preferred language and/or need for auxiliary aids and services—at any touchpoint with the beneficiary—the plan must provide required materials in that language and/or accessible format until the beneficiary requests that the plan provide required materials in a different manner.

Elevance Health supports beneficiaries who are limited-English proficient or require auxiliary aids. In all written communications, we include the Babel sheet that offers over 15 translation languages. Our partners can fulfill requests in over 170 languages. We also include a statement about offering materials in alternate formats (Braille, audio, etc.) at no cost on request.
For all of our written communications, we strive to create base content at a 5th grade reading level or lower, using plain language. Simple language, clear graphics, and white space all lead to content that is easier to comprehend, both in English as well as translated languages.

We agree with CMS that health plans and plan sponsors should acknowledge a beneficiary's preferred language/accessible format and carry that preference forward when practicable. There are many standard notices and documents where health plans have already translated and created auxiliary aids that can and should be used once a beneficiary has made their preference known.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

However, there are also many communications sent to beneficiaries that are not standard notices, and are also unique to a specific situation, which would need to be separately translated into a language/aid as its own document. Many of these communications, such as a UM decision or a care plan, need to be communicated quickly and within required timelines.

Turnaround times would be the most challenging element of this requirement. For accessible formats and auxiliary aids—given the complexity of audio, data, and Braille conversion—the request for a unique document to be converted can take 2-4 weeks to complete. For unique documents to be translated into another language, the turnaround time is 1-2 weeks. This completion time runs counter to the need to provide many unique communications quickly.

Recommendation: Elevance Health recommends CMS finalize this proposal only with respect to model materials. For non-standard communications, we strongly urge CMS first establish a multi-stakeholder workgroup to address how language translations and conversions to aids could be accomplished for non-standard communications within the required timelines and develop best practices to support beneficiaries.

Digital Health Literacy & Telehealth

CMS proposes to add requirements for health plans to develop and maintain procedures to identify and offer digital health education to beneficiaries with low digital health literacy to assist them with accessing any medically necessary covered telehealth benefits. We support CMS' digital health literacy goals to enable Medicare beneficiaries to access benefits. Digital access is a key social driver of health. Digital health literacy, as defined by the World Health Organization (WHO), is the ability to seek, find, understand, and appraise health information from electronic services and apply the knowledge gained to addressing or solving a health problem.[34]

Barriers to health literacy and digital health literacy negatively impact health outcomes, reduce adherence and treatment recommendations, and increase medical costs. We are working to ensure beneficiaries have the right tools to make the best healthcare decisions by making health information easier to understand and act upon. Consistent with research, we have found that many Medicare beneficiaries prefer audio-only telehealth because it's easier to access.[35] In addition, Black and Hispanic/Latino beneficiaries, as well as dually eligible beneficiaries with multiple complex conditions, are less likely to have access to video and

[34] National Library of Medicine. An Introduction to Health Literacy (accessed January 2023): shorturl.at/bJZ18
[35] Elevance Health Public Policy Institute. "Virtual Healthcare Use Among Medicare Advantage Members Before and During the COVID-19 Pandemic." November 2020. tinyurl.com/3ppyfuxc.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

audio technologies than other groups of MA beneficiaries, potentially compounding disparities in outcomes.[36] [37]

We are committed to leveraging digital technologies to improve efficiency and beneficiary experiences, convert data into insights, and create a platform that connects stakeholders across the health ecosystem to improve health equity. Under our member-centric Sydney platform and mobile app, our focus is broader than telehealth as health-related competencies and digital literacy are interwoven and mutually dependent. We are leveraging health literacy data to help identify rural areas, where health literacy and digital literacy needs are significant, to focus our work.[38] We have prioritized digital health literacy as a key lever in closing the digital divide for our beneficiaries and defined digital determinants of health based on three key components:

- **Broadband Access:** Pew Research found that 43% of adults with incomes below $30,000 a year report not having home broadband services;[39]
- **Smartphone Dependence:** According to Pew Research, for about 1 in 6 Americans, a mobile device is their only access to the internet while at home;[40] and,
- **Digital Health Literacy:** The U.S. Centers for Disease Control and Prevention (CDC) reports that, "[w]hile 75% of [those surveyed] said they had skills to evaluate online health resources, only 60% reported confidence in evaluating the quality of these resources and making health decisions based on that information."[41]

This strategic undertaking has involved assessing the current state of digital health literacy among Elevance Health beneficiaries and developing programs and procedures to improve digital health literacy. We are working to meet beneficiaries where they are and empower them through processes and approaches to get care quickly, improve beneficiary knowledge and experience, and increase access to high-quality care. To achieve these goals, we are:

- Developing educational materials that are accessible, written in plain language, and encourage peer-to-peer learning. For example, our Live Health Online platform has a video educating beneficiaries about how telehealth may be able to help them avoid an Emergency Room (ER) visit;
- Helping beneficiaries understand their benefits and how to access services digitally;

[36] AJMC. "Differences in the Use of Telephone and Video Telemedicine Visits During the COVID-19 Pandemic." January 14, 2021. tinyurl.com/2or2482g.
[37] PubMed.gov. "Disparities in the Use of In-Person and Telehealth Primary Care Among High- and Low-Risk Medicare Beneficiaries During COVID-19." December 13, 2021. https://pubmed.ncbi.nlm.nih.gov/34926805/.
[38] healthliteracymap.unc.edu
[39] Vogels, Emily. Pew Research Center. Digital divide persists even as Americans with lower incomes make gains in tech adoption. (June 2021): https://www.pewresearch.org/fact-tank/2021/06/22/digital-divide-persists-even-as-americans-with-lower-incomes-make-gains-in-tech-adoption/
[40] Pew Research Center. Mobile Fact Sheet. (Accessed January 2023): https://www.pewresearch.org/internet/fact-sheet/mobile/
[41] Centers for Disease Control and Prevention. eHealth Literacy. (Accessed January 2023): cdc.gov/healthliteracy/researchevaluate/eHealth.html

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

- Engaging providers in digital health learning tools to help build trust within the Medicare population;
- Improving access to digital health resources and telehealth benefits through digital health navigators and care coordinators;
- Helping beneficiaries gain broadband and internet access; and,
- Creating how-to videos for our Sydney Health app and our digital health programs.

By offering simple, transparent beneficiary experiences, we are working to build confidence, increase patient satisfaction, and support beneficiaries who need education and assistance to engage digitally to use their benefits. We are committed to collaborating with CMS to understand and improve Medicare beneficiaries' level of health and digital health literacy.

Recommendations: We encourage CMS to confirm that the agency is using the WHO definition to measure digital health literacy and provide flexibility as health plans innovate to expand access to telehealth, digital access, and digital literacy in the Medicare population. Given that there are currently different definitions, standards, and vocabulary around digital health literacy, we encourage CMS to convene a working group to develop research-driven standards and further studies. We also encourage the government to do annual assessments of digital health literacy across the Medicare population to help inform best practices in the working group using the eHealth Literacy Scale (eHEALS). The last such national study was published in 2003. We have found the eHEALS 8-item measure of consumers' knowledge, comfort, and perceived skills at finding, evaluating, and applying electronic health information to health problems is a helpful benchmark to inform our work.[42] [43]

Coverage Determinations and Prior Authorizations

The application of health plan medical policy is one of the most effective ways to ensure the right care is provided at the right place at the right time. Experts have found that hundreds of billions of dollars are wasted every year in healthcare – and that beneficiaries often receive care that is costly, inappropriate, unneeded, ineffective, or unnecessary. Elevance Health's medical policies are developed by over 100 physicians and clinicians that have expertise in their specialties and are based on both peer-reviewed studies in medical literature and guidelines that reflect a strong clinical consensus among the medical specialty communities. By ensuring care is aligned with evidence-based medicine, Elevance Health drives towards

[42] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1794004/#:~:text=The%20eHEALS%20is%20an%208,health%20information%20to%20health%20problems.
[43] https://www.jmir.org/2006/4/e27

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

improved outcomes and reduced readmissions in a way that is aligned with both the goals of the Administration and Stars Rating quality measures.

Elevance Health acknowledges that that the application of medical policies—such as in the case of prior authorizations—can create friction and frustration for providers and patients. That is why we have been a leader in both transparency (as described below) and using technology to make the process of obtaining an approval as fast and as efficient as possible. To this end, we continue to develop and offer solutions to streamline prior authorization processes for our care provider partners with technology that makes prior authorization submissions easier and decisions faster. We also offer innovative programs that reward those providers taking downside risk and adhering to evidence-based standards, by relaxing or eliminating prior authorization requirements, so that providers may focus on rendering care, which will improve the quality of care.

Elevance Health also supports the goals of promoting electronic Prior Authorization (ePA) and has invested in developing electronic solutions to facilitate the ease and speed of medical management processes as well as working with industry stakeholders to develop ePA solutions. For example:

- **The DaVinci Project / HL7.** We are highly active with public-private partnerships to enhance the timely and actionable exchange of health data such as Health Level Seven (HL7) International. Elevance Health's activity includes participating in the development of new FHIR data standards for ePA, taking part in FHIR "Connect-athons," the U.S. Realm Steering Committee, the Attachments Work Group, the Payers/Providers Work Group, and The DaVinci Project, which was highlighted in the CMS presentation to the Office of the National Coordinator of Health Information Technology (ONC) as a tool to help reduce physician burden.
- **Participation in Electronic Data Interchange Working Group.** Elevance Health participates in the Attachments & Prior Authorizations Support work groups at the Workgroup for Electronic Data Interchange (WEDI), which serves in an advisory role to the Secretary of the U.S. Department of Health and Human Services (HHS) on matters related to the use of electronic transactions in healthcare. WEDI's work has contributed to other CMS rulemaking on the Health Insurance Portability and Accountability Act (HIPAA) X12 electronic standard transactions for referral certification and authorization (278) and healthcare attachments (275).[44]

[44] Proposed rule, Administrative Simplification: Adoption of Standards for Healthcare Attachments Transactions and Electronic Signatures, and Modification to Referral Certification and Authorization Transaction Standard, 87 Fed. Reg. 78438 (Wednesday, December 21, 2022).

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

We also remain flexible to the care circumstances of our beneficiaries. For example, in response to the COVID-19 pandemic, we waived prior authorization requirements for Skilled Nursing Facility transfers and other services in order to free up hospital bed capacity. We work within federal and state guidelines, collaborating with stakeholders to appropriately adjust our care management programs for the benefit of our members.

Transparency of Medical Policies

Elevance Health supports the transparency of medical policies used to determine whether specific items and services are covered (and under which circumstances) and has made its medical policies available on its public website for over a decade.[45] Publicly publishing medical policies helps demonstrate that decisions are being made based upon clinical evidence, which helps build beneficiary and stakeholder trust.

Recommendation: Elevance Health supports the transparency provisions in the proposed regulation. This includes the requirement for MA plans to only use internal coverage criteria to the extent it is made publicly available, and requiring:

- A publicly accessible summary of evidence that was considered during the development of the internal coverage criteria;
- A list of the sources of such evidence; and,
- An explanation of the rationale supporting the adoption of the coverage criteria.

Ensuring all health plans operate with this transparency will help ensure beneficiary trust in the program.

Involvement of Medical Directors or other Appropriate Healthcare Professionals in Medical Policy and Decisions

CMS proposes that the MA organization's Medical Directors be involved in ensuring the clinical accuracy of medical necessity decisions where appropriate. Elevance Health believes the direct involvement of Medical Directors or other appropriate healthcare professionals is a critical element of the medical necessity process, and Elevance Health follows this practice today.

[45] Our medical policies are available at this site: https://www.anthem.com/provider/policies/clinical-guidelines/

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Recommendation: Elevance Health supports this provision and recommends CMS finalize it. This provision would help build trust for the program.

Qualifications of Staff Making Medical Necessity Decisions

CMS proposes that the existing general requirement that the physician or other appropriate healthcare professional have sufficient medical and other expertise be replaced by a requirement linking the requisite expertise of the reviewer to the specific service that is the subject of the organization determination request. Elevance Health strongly believes the health plan should have the ability to determine which physician or healthcare professional is qualified to conduct the initial organization determination, including what specific expertise is required for the service requested, and Elevance Health already takes this approach.

But Elevance Health does not believe there should be an exact match between the service requested and the qualifications of the reviewer. CMS gives as an example in the proposed rule a prior authorization request for a home nebulizer, which CMS states would be appropriate for a respiratory therapist to review.[46] However, respiratory therapists are not physicians, and they cannot order a home nebulizer, while physicians can. Internal medicine physicians are familiar with the reasons why a home nebulizer might be medically necessary, such as for severe asthma or Chronic Obstructive Pulmonary Disease (COPD). If, as CMS states, review of a request for referral to a surgeon for excision of a thyroid nodule does not require review by a surgeon, so too a request for a home nebulizer need not be reviewed by a pulmonologist or allergist when an internal medicine physician has familiarity with nebulizers.

Recommendation: Elevance Health supports this provision and recommends CMS finalize it, with the caveat that CMS should not require that there be an exact match between the service requested and the qualifications of the reviewer. This provision would help build trust in the program.

Conforming MA Coverage Policy to FFS Medicare

FFS Medicare's Medical Policy Falls Short of Ensuring Appropriate Care

CMS' existing definition of medical necessity requires that the service be safe and effective and furnished in accordance with the accepted standards of medical practice. Unfortunately,

[46] 87 Fed. Reg. at 79510.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

CMS' existing medical policy used in the FFS Medicare program falls short of this objective in the following ways:

- **FFS Medicare's medical policies lack specificity:** FFS Medicare has a large number of coverage policies that are vague and do not provide appropriate guidance, meaning the proposed regulation may have the practical impact of inhibiting any coverage denials in those areas, even in cases where the service being provided presents a safety risk. Specifically, the key areas of radiology and musculoskeletal conditions exhibit such a lack of specificity that health plans would be left unsure whether they could use their own policies that contain sufficient detail:
    - Current National Coverage Decisions (NCD) for CT and Magnetic Resonance Imaging (MRI) (the two most utilized advanced imaging exams) generally do not provide any condition-specific criteria for assessment of imaging appropriateness, aside from limited exceptions for relatively uncommon services. These NCDs require that services be "reasonable and necessary," but provide no detail on the criteria needed to establish that definition.
    - Health plans fill the explanatory gap by providing a definition of medical necessity (through an evidence-based appropriateness framework) via specific clinical criteria that establish appropriateness for any CT or MRI request.
    - For example, the most common reason to order an MRI of the brain is for evaluation of headache, and there is longstanding multi-specialty consensus recommending imaging only in the presence of certain clinical risk factors (a position by which MA plan guidelines are aligned).[47] However, the NCD 220.2 for MRI does not include any such criteria for this indication, instead only stating that "MRI is useful in examining the head, central nervous system, and spine… The inherent tissue contrast resolution of MRI makes it an appropriate standard diagnostic modality for general neuroradiology," perpetuating the inappropriate use of MRI against evidence-based practice in this space.
- **FFS Medicare does not have medical policies in key areas:** In addition to those areas of medical policy that are vague, there are areas of benefit classes where FFS Medicare has no medical policy. While the proposed regulation would allow health plans to use their own medical policies in such circumstances, the rule appears to not allow guidelines built

[47] National Institute for Health and Care Excellence, Headaches in over 12s: diagnosis and management, (2012) London, UK, National Institute for Health and Care Excellence; Douglas, AC, et al, Expert Panel on Neurologic Imaging. ACR Appropriateness Criteria® Headache. [Online Publication]. Reston (VA) American College of Radiology (ACR); 2013. Available at: https://acsearch.acr.org/docs/69482/Narrative/; Stephen D. Silberstein. Practice parameter: Evidence-based guidelines for migraine headache (an evidence-based review): Report of the Quality. Standards Subcommittee of the American Academy of Neurology. 2000;55;754 Neurology. (US Headache Consortium).

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

upon a clinical consensus that has not yet been incorporated into the published medical literature:

- For example, there is a clinical consensus that an X-Ray or ultrasound should often be ordered before demonstrating a need for a CT scan. However, this approach is not reflected in the FFS Medicare coverage policy.

Worse Health Outcomes and Lower Quality Care for Beneficiaries

Elevance Health supports CMS' efforts to improve the health outcomes for beneficiaries. CMS has acknowledged the importance of medical policy in achieving this goal in its final 2023 Outpatient Prospective Payment System (OPPS) rule, where CMS states that "prior authorization is an effective mechanism to ensure Medicare beneficiaries receive medically necessary care."[48]

By forcing health plans to adopt vague, non-existent, or outdated medical policies, the proposed regulation would harm plan sponsor's efforts that utilize medical policies to improve beneficiaries' health. For example, there is extensive evidence that MRI of the low back should only be done for back pain after a course of non-operative management, because most uncomplicated low back pain improves with such treatment and because MRI is known to generate many false positive results in the spine (findings that are abnormal on imaging, but not the cause of pain), which often drive additional procedures/surgery and imaging.[49]

However, this approach is not reflected in the FFS Medicare coverage policy, which would expose beneficiaries to lower quality care and the potential harms of unnecessary procedures and services as compared to the application of existing health plan medical policy that aims to only use imaging when medically necessary. Potential harms of imaging overutilization include false positive imaging results leading to inaccurate diagnosis resulting in unnecessary subsequent testing and potential overtreatment. Unnecessary imaging exams also directly expose patients to harms including contrast reaction, nephrotoxicity, and exposure to unnecessary ionizing radiation.

[48] Final Rule, Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating; COVID–19, 87 Fed Reg 71748, 72226 (Wednesday, November 23, 2022).
[49] Chou R, Qaseem A, Snow V, et al. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. Ann Intern Med. 2007;147(7):478-91;
Patel ND, Broderick DF, Burns J, et al. ACR Appropriateness Criteria Low Back Pain. J Am Coll Radiol. 2016;13(9):1069-78.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Higher Costs and/or Fewer Benefits for Beneficiaries

It is widely accepted that prior authorization reduces costs by ensuring care paid for by the plan is evidence-based. As the proposed regulation would make health plan medical policies less stringent in key areas (by requiring conformity to FFS Medicare in those areas), it would increase costs. Higher costs for MA translate to higher premiums and/or fewer supplemental benefits for beneficiaries.

Reducing Beneficiary Choice

As outlined in more detail below, MA was created as an alternative to FFS that intentionally has a more managed medical framework, including both networks and medical management. Beneficiaries place so much value on MA as an alternative that almost half of Medicare beneficiaries made a proactive choice to enroll in MA. If CMS requires MA plans to adopt the less robust medical policies in FFS Medicare—as would be required in the proposed regulation—there would be less savings available to beneficiaries which would materialize in the form of higher premiums and/or fewer benefits.

Increased Healthcare Waste and Exacerbating Medicare's Financial Challenges

CMS has agreed with the perspective that prior authorization helps reduce healthcare waste and mitigates Medicare's financial challenges. Specifically, in its final 2023 OPPS rule, CMS states that "prior authorization is an effective mechanism to ensure Medicare beneficiaries receive medically necessary care while protecting the Medicare Trust Funds from unnecessary increases in volume, by virtue of improper payments, without adding new documentation requirements."[50] A requirement that MA plans adopt FFS Medicare's less robust medical policies would exacerbate Medicare's financial challenges and run contrary to CMS' perspective outlined above.

Inconsistent with Congressional Intent for Part C

When Congress created Medicare Part C in 1997, goals included offering beneficiaries an improved option that would be different from Medicare (including through the use of medical management), would be more familiar to beneficiaries previously covered under employer-sponsored health plans, would improve care, and would reduce costs for the Medicare

[50] Final Rule, Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating; COVID–19, 87 Fed Reg at 72226.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

program. The MA program has successfully met those goals and is in high demand by beneficiaries, now representing nearly half of Medicare enrollment.

By proposing that MA plans conform their coverage policies to FFS Medicare, CMS is working against all of those goals stated above in the following ways:

- **Worse health outcomes:** As described in more detail below, FFS Medicare coverage guidelines can be vague or not reflect the latest medical research in key areas; requiring health plans to adopt them would eliminate guidelines that are proven to improve health outcomes and reduce health risks for beneficiaries.
- **Reduced beneficiary choice:** Removing differentiation on coverage guidelines between MA plans and FFS Medicare (and between MA plans themselves) removes an important element of beneficiary choice.
- **Lower value care:** Health plans work with providers on medical management policies to achieve better health outcomes and improvements in the Star Rating quality measures, affordability, and product design through value-based care arrangements.
- **Higher costs:** Health plan coverage guidelines are proven to help reduce costs; eliminating them would increase costs to the Medicare program and result in higher premiums and/or reduced benefits for beneficiaries.
- **Less familiarity for consumers with coverage under employer plans:** MA health plan coverage guidelines largely mirror the coverage guidelines that apply to coverage under employer-sponsored health plans. Forcing health plans to adopt FFS Medicare coverage guidelines would eliminate that element of consumer familiarity when transitioning from an employer plan to Medicare.

Recommendation: Elevance Health recommends that CMS withdraw its proposal to require health plans to conform to FFS Medicare's medical guidelines. Withdrawing the proposal will avoid (1) beneficiaries receiving worse care, higher premiums, and fewer benefits; (2) reducing beneficiary choice by devaluing MA; and (3) exacerbating Medicare's financial challenges.

Prohibiting Medical Policy that Requires One Item/Service to be Furnished Prior to Receiving the Requested Item/Service

CMS proposes to prohibit health plans from applying medical policy that requires one item/service to be furnished prior to receiving the requested item/service. One of the most

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

important elements of medical policy is ensuring that a medical item or service is provided at the right time (that is, the right step in the course of treatment). Medical policy is often designed to ensure that a less invasive item/service is furnished prior to a more invasive item/service. This approach increases safety and is supported by evidence-based medicine.

For example, clinical consensus and medical literature, including Appropriate Use Criteria from the American College of Radiology, show that it is often appropriate for patients to have an x-ray or ultrasound before a CT scan or MRI, as these exams may provide sufficient diagnostic information with low or no radiation exposure. In addition, x-ray or ultrasound are often used in a complementary fashion to determine which CT or MRI imaging exam is most appropriate. If CMS' proposed provision prohibiting medical policy that requires one item/service to be furnished first were to go into effect, it would require providers to provide care that is inconsistent with evidence-based clinical consensus, potentially expose beneficiaries to more radiation or other harms of unnecessary imaging, and risk performance of diagnostically suboptimal and/or clinically redundant exams. Furthermore, requiring health plans to cover a more expensive medical test when a more cost-effective test would afford the same or better diagnostic data would increase costs for the Medicare Trust Funds and also increase costs and/or reduce benefits for beneficiaries.

Recommendation: For the above reasons, Elevance Health recommends CMS withdraw the proposal to prohibit health plans from applying medical policy requiring one item/service to be furnished prior to receiving the requested item/service. Withdrawing this proposal would avoid worse care for beneficiaries associated with the provision of potentially harmful items/services that could have been avoided, consistent with medical literature and evidence-based medicine. Withdrawing the proposal would also avoid higher premiums and/or fewer benefits for beneficiaries and exacerbating Medicare's financial challenges.

While CMS notes the agency is not proposing to revise regulations which authorize MA plans to use step therapy policies for Part B drugs, we reiterate the importance of step therapy in Part B, Durable Medical Equipment (DME), and Continuous Glucose Monitoring (CGM). Step therapy is a valuable tool to encourage beneficiaries to use clinically superior drugs that are therapeutically comparable to protect patients and taxpayers from a high-priced drug, when there is a more reasonably priced, and clinically similar alternative. It is critical to avoid additional limitations on the use of step therapy that could undermine the benefits of this valuable clinical management tool.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Requiring Authorizations be Valid for Entire "Course of Treatment"

CMS proposes to require prior authorization approvals be valid for the entire "course of treatment." Requiring a prior authorization to be valid for the entire "course of treatment" is overly broad and may create a situation where there is no clear time limitation and potentially no limitation on a provider continuing to furnish services experts would not consider tied to the original approval. Such a policy would increase waste in the healthcare system—in some cases for multiple years for a single patient. Of note, there is nothing in the proposed provision that would differentiate between diagnostics and therapy.

It is also unclear whether an MA plan could conduct concurrent reviews for post-acute care; disallowing concurrent review in the post-acute setting would not ensure that the beneficiary was placed in the best setting. MA plans need to retain the ability to conduct concurrent reviews for post-acute care and rehabilitation, because there is a need to monitor the patient's condition. Additionally, disallowing post-acute concurrent review could potentially exhaust a beneficiary's benefits, leaving them with no remaining benefits when needed.

Recommendation: For these reasons, Elevance Health recommends that CMS withdraw its proposal to require prior authorization approvals be valid for the entire course of treatment. Withdrawing the proposal would avoid the provision of wasteful services that drive up premiums and/or reduced benefits for beneficiaries while exacerbating Medicare's financial challenges. Additionally, should this proposal apply to Part B drugs, we recommend CMS give health plans the flexibility to establish the length of the approval for therapies on a case-by-case basis. For example, the length of approval may be for the duration of the planned course of treatment or for as long as the beneficiary remains in the plan.

90-Day Transition Period when Beneficiaries Switch MA Plans

CMS proposes to require health plans to have policies for using prior authorization that provide for a minimum 90-day transition period for any ongoing course(s) of treatment when a beneficiary has enrolled in an MA plan after starting a course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider. This provision would also apply to beneficiaries who are new to Medicare.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Elevance Health supports the general goal CMS is trying to achieve to ensure care is not disrupted when a beneficiary transitions plans. We believe this goal is already achieved through the existing practice where prior authorization approvals are "grandfathered" that allows a provider to demonstrate to the new MA plan that prior approvals already took place. In our view, this approach works well today.

CMS' proposal would switch the onus such that plans would need to continue to pay the provider—irrespective of whether the provider can demonstrate that a prior approval was achieved under the previous plan. CMS' proposal would also extend to out-of-network providers—even when the new health plan's medical policies are not being followed. This change would increase costs, leading to higher premiums and/or fewer benefits for beneficiaries, while exacerbating Medicare's financial challenges.

Recommendation: Elevance Health recommends CMS withdraw its proposal to require health plans to have policies for using prior authorization that provide for a minimum 90-day transition period for any ongoing course(s) of treatment when a beneficiary has enrolled in an MA plan after starting a course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider. CMS should instead keep in place its existing policy where prior authorization approvals are "grandfathered" that allows a provider to demonstrate to the new MA plan that prior approvals already took place. This approach would avoid increased premiums and/or fewer benefits for beneficiaries and exacerbating Medicare's financial challenges.

Utilization Management Committee

CMS proposes to require MA organizations to establish a UM committee to operate, similar to a P&T Committee, which would annually review UM policies, including prior authorization.

Elevance Health supports the concept of ensuring UM policies (including those for prior authorization) are reviewed regularly by individuals at the plan with diverse clinical experience and expertise. However, we also believe such a requirement should be applied in a way that is sufficient while minimizing duplication and administrative costs. For example, NCQA accreditation already requires accredited plans to have qualified medical personnel review UM criteria and decisions.

Recommendation: Since NCQA accreditation already requires accredited plans to have qualified medical personnel review UM criteria and decisions, Elevance Health requests that CMS avoid administrative duplication by allowing this provision to be satisfied by a plan's NCQA accreditation. Otherwise, there will be additional administrative costs and duplication

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

that would increase costs, resulting in higher premiums and/or reduced benefits, and exacerbating Medicare's financial challenges. In addition, should this proposal apply to Part B drugs, in order to reduce additional administration burden on plan sponsors, we recommend CMS allow the sponsor's existing Part D P&T Committee to have oversight of certain UM coverage policies.

Request for Information (RFI): Termination of Services in Post-Acute Care

CMS states it has received complaints that allege that MA organizations are increasingly terminating beneficiaries' coverage of post-acute care before the beneficiaries are healthy enough to return home. CMS is soliciting feedback from stakeholders that have information related to this situation, and investigating internally, to get a more thorough understanding on the issue.

Upon reviewing this RFI, we reviewed our Grievance & Appeal data capturing challenges to our coverage determinations for post-acute care from January 2021 through October 2022. Our data shows the following:

- Over 92% of post-acute care appeals of our coverage decisions were upheld by the Independent Review Entity; and,
- Of those overturned, the number one reason was providers not submitting adequate information with the authorization, including documents supporting medical necessity.

This data demonstrates that Elevance Health is making post-acute care determinations consistent with evidence-based medicine. If CMS is interested in reviewing our data further and discussing the issue with our medical experts, we would be happy to do so.

Marketing

Elevance Health strongly believes all MA and Part D marketing must be clear, accurate, and compliant with CMS regulations and sub-regulatory guidance, including the Medicare Communications and Marketing Guidelines (MCMG). All marketing must meet these standards to ensure beneficiaries are able to make the best healthcare choices to meet their unique needs and preferences. To best meet this objective, we have industry-leading processes in place, including the following:

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

- **Carefully generating and reviewing marketing materials that meet CMS requirements and provide clear and accurate information to beneficiaries:** Elevance Health has detailed compliance processes in place to ensure all marketing materials contain clear and accurate information and that materials meet all CMS requirements.
- **Reviewing TPMO marketing materials to the largest extent possible:** Consistent with CMS guidance, we have robust compliance programs in place to oversee the activities of TPMOs, agents, and brokers where a contract exists between Elevance Health and those individuals/entities. We also utilize CMS' HPMS process for reviewing marketing materials submitted by third-party entities, often conduct TPMO marketing reviews of documents before they are even submitted to HPMS, and opt out of any materials that contain inaccurate or potentially misleading information.
- **Quickly addressing concerns raised by any stakeholder:** We quickly investigate and work to address marketing-related complaints from sources raised through any channel, including the Complaint Tracking Module. When patterns emerge, we work with our partner organizations to quickly rectify the issue, which has included rejecting participation in certain marketing materials.
- **Consistently generating compliance education campaigns:** We consistently educate sales agents about existing and new CMS marketing requirements to ensure compliance, including the importance of reviewing all materials for accuracy and ensuring consumer confusion is mitigated to the largest extent possible. We focus on educating beneficiaries about their health plan choice, before, during, and after enrollment.
- **"Secret shopping" our sales partners:** We regularly put our own employees in the shoes of a beneficiary and go through a sales experience with our sales partners to improve beneficiaries' experience and ensure compliance with CMS requirements.

TPMO Oversight Recommendations to Reduce Abrasion and Improve Trust

Elevance Health is committed to ensuring beneficiaries have the necessary information to make the coverage choices that best meet their needs. CMS' final 2022 MA and Part D rule aimed to clarify regulations to make health plans accountable for its contractors and subcontractors engaging in marketing activities. Such an approach leaves a number of oversight challenges, including:

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

- TPMOs typically market the plan options of a large number of companies and will often continue its actions even when a single plan opts-out due to concerns the activity does not meet all CMS requirements;
- Despite concerns health plans may raise about marketing accuracy, CMS may approve marketing materials leading to inconsistency and confusion about interpretations related to existing requirements;
- Health plans cannot take collective actions against third-party bad actors due to antitrust constraints; and,
- TPMOs may contract with entities which health plans have no contract or are not even aware of. For example, many of the existing marketing entities generating sales leads do not have direct or indirect contractual relationships with health plans.

Elevance Health shares policymakers' goal of protecting beneficiaries from confusing and potentially misleading Medicare marketing information that may cause beneficiary confusion or harm. In addition, we agree with policymakers' assessment that much of the confusion and abrasion is not due to health plans themselves, but rather the activity of a relatively small subset of TPMOs and their downstream entities.[51] Given these challenges, CMS is in the best position to quickly evaluate and—if necessary—stop marketing activity that does not meet CMS' requirements.

Recommendation: We recommend CMS work with stakeholders and Congress to obtain sufficient regulatory authority and staffing to ensure the activities of all marketing entities are compliant with CMS requirements with a more streamlined oversight framework. Such a framework could do the following:

- **Require all individuals/entities marketing MA and Part D to register with CMS:** Congress could establish a requirement that all entities performing an MA/Part D marketing function register with CMS and be subject to direct audits and fines for non-compliance.
- **Substantial fines for not being registered:** Because bad actors (for example, entities performing aggressive robocalls) are unlikely to do the right thing and register with CMS, Congress could mandate fines that would prevent bad actors from continuing to perform misleading marketing.

[51] Centers for Medicare & Medicaid Services: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs (January 12, 2022): https://www.govinfo.gov/content/pkg/FR-2022-01-12/pdf/2022-00117.pdf

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

While action from Congress may be needed to provide sufficient authority and staffing for CMS to directly regulate TPMOs and downstream entities, we recommend CMS take the following additional steps under its existing authority to mitigate non-compliant marketing:

- **Preserve federal Medicare preemption:** While state partnerships are important, it is critical to preserve and strengthen federal Medicare preemption protections to ensure consistency in addressing misleading marketing materials across the country. A patchwork of state regulations on MA marketing materials would undermine strong and consistent federal standards and risk inconsistent enforcement regimes. Preemption consistently applied to marketing materials in the Medicare+Choice program prior to 2003, and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) reinforced and strengthened preemption.[52] The broad reach of the Congressional intent behind the Medicare Act's preemption clause must be maintained to preserve beneficiary protections.
- **Create a consolidated document containing all marketing requirements with examples for stakeholders to reference:** Since the regulatory requirements related to marketing are not published in one place for stakeholders to reference, we recommend CMS compile and codify marketing requirements through the MCMG with a comment opportunity. Until guidance is published and codified in a single place, bad actors may take advantage of a lack of clarity. Furthermore, different parts of CMS may interpret requirements differently. The compilation of requirements should include examples of compliant and non-compliant materials and tactics to improve clarity.
- **Ensure consistent enforcement:** Today, it is our experience that staff across CMS' regional offices do not provide consistent answers on whether a specific marketing material is compliant. We recommend the process for review and enforcement be centralized by CMS to provide consistent enforcement to ensure the delivery of clear and compliant information to beneficiaries.
- **Revise the process for TPMO material approval:** We recommend CMS improve the current HPMS marketing material filing approach such that material filed by TPMOs is approved by a lead plan. The lead plan would be responsible for ensuring the material meets all of CMS' standards, enforcing accountability and cutting down on duplication.
- **Establish a compliance resolution process for reports of potentially non-compliant marketing materials or tactics:** In addition to the filing process described above, we recommend CMS develop a process where stakeholders can easily report non-compliant marketing with a framework for swift resolution.

[52] CooperScully: Trends In Managed Care Preemption (2006): https://www.cooperscully.com/uploads/seminars/Leininger%20-%20Trends%20in%20Managed%20Care%20Preemption.pdf

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

- **Perform TPMO-targeted trainings:** CMS should provide consistent training to TPMOs and their downstream entities to ensure understanding of marketing requirements.

Proposed Marketing Requirements Supported by Elevance Health

We appreciate CMS' efforts to close marketing loopholes in its 2024 regulation to protect beneficiaries. Specifically, Elevance Health supports CMS' proposals to:

- **Prohibit TPMOs from selling information to other TPMOs (while clarifying contact information can still be provided from TPMOs to health plans):** We generally support CMS' proposed prohibition on TPMOs selling information to other TPMOs. This would help avoid situations where bad actors pass personal contact information several times to multiple entities, creating aggravating situations for consumers.
    - However, we seek an important clarification that would ensure a TPMO can provide the relevant health plan(s) with contact information for follow-up with the consumer. For example, if a consumer expresses interest in enrolling in a particular health plan, that TPMO should have the ability to pass that information along for appropriate follow-up.
- **Modify the TPMO standard notice (with request to streamline the language):** We appreciate CMS' effort to ensure consumers understand that a TPMO may not be presenting all options available in a particular service area.
    - However, we recommend CMS streamline the language because we have found that complex disclaimers can confuse consumers. We therefore suggest CMS make the disclaimer as short as possible and reference only 1-800-MEDICARE and Medicare.gov as sources information for consumers.
- **Prohibit advertising that markets something as "savings" in a misleading way:** We support ensuring assertions made in advertising reflect accurate information. We support CMS' proposal to prohibit marketing a product as providing significant "savings" that are based on a comparison of typical expenses borne by uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a Medicare beneficiary. In addition, we want to ensure that health plans are not interpreting the guidance differently, so we ask CMS to provide additional examples of scenarios and what language is appropriate.
- **Require health plans to have an agent/broker monitoring and oversight plan (with needed clarifications):** We monitor the activities of our agents and brokers, including call

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

monitoring and secret shopping, and we support ensuring all health plans perform that function.

  - However, we request the following clarifications:
    - CMS should clarify what it means by a "healthy sampling;"
    - For an agent/broker that a health plan does not employ or have a contractual relationship with, we urge CMS to impose agent/broker fines directly; and,
    - CMS' acknowledgment that real-time monitoring cannot take place between a health plan and employees of an external organization, such as a TPMO, because systems do not exist to monitor employees of another organization in a real-time way (for example, external call center). In addition, monitored calls could involve beneficiaries enrolling in a different health plan, which would violate HIPAA privacy rules.

- **Establish required questions that must be asked prior to enrollment (with needed clarifications):** We support requiring entities go through a CMS-developed list of items that must be discussed with the beneficiary. CMS already approves Elevance Health's sales script, and we appreciate the opportunity to ensure we are being thorough with beneficiaries and compliant with CMS' requirements.
  - However, beneficiaries should only be asked a question once during the entire sales and enrollment process, not multiple times as could be the case if agents/brokers are required to ask the same questions that already exist in a pre-enrollment checklist. The scripting process is the best way to ensure these questions get asked, and we would like to work with CMS to ensure beneficiaries are asked an appropriate number of streamlined questions.
- **Clarify the existing requirement to record calls (with needed clarification):** We support CMS' proposal to clarify that the requirement to record calls is limited to calls regarding sales, marketing, and enrollment, and to extend the requirement to web-based technology.
  - However, we seek clarification that a call can continue if the beneficiary asks not to be recorded. Under existing regulation, we are concerned that the requirement to record calls could be interpreted as requiring the call be terminated if the beneficiary requests that the call is not recorded. We believe the call should be able to continue unrecorded if a beneficiary makes such a request, otherwise there would be beneficiary abrasion and complaints, as we would not be able to meet the beneficiary's needs.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

- **Prohibit the use of superlatives without concurrent data backing-up the claim:** We agree that all superlatives used in marketing materials must be backed-up with evidence. We also request CMS ensure this provision is enforced consistently across all languages as superlatives do not always translate consistently between languages.

Creating Barriers to Face-to-Face Marketing Interactions

CMS is proposing two major changes that would have the effect of limiting face-to-face sales interactions: (1) a 48-hour wait time between an SOA being filled out and an appointment being made, and (2) separating sales events from educational events. Both of these changes add waiting times, which would result in fewer face-to-face interactions, and drive more tele-sales activities.

We have found that a substantial portion of consumers prefer face-to-face sales. Particularly for older adults, face-to-face interactions are the format many consumers find to be the most helpful to build trust, gain the right information, and make the choice that best meets their needs. Telephonic sales are robust and valuable; however, relationships can be strengthened by in-person interactions and ongoing conversations.
Independent studies have similarly concluded that older adults strongly prefer in-person interaction. In a study published in 2021 by BMC Health Services Research that interviewed various cohorts of older adults concluded that:

- Most older adults have strong preferences for obtaining information in-person regarding benefits, cost, and other plan information;
- Few of those interviewed used the available internet resources, and in fact most of them mentioned that they did not have a computer/smart device with internet capabilities; and,
- Among those who used and appeared to be comfortable with navigating the internet, www.Medicare.gov was not discussed as a useful resource for making decisions regarding health insurance.[53]

Another study published in Educational Gerontology in 2016 further concluded that face-to-face communication is the most preferred method of communication for older adults in the U.S.[54] For this reason, Elevance Health is opposed to changes that would make face-to-face

[53] Rivera-Hernandez M., Blackwood K.L., Mercedes M., Moody K.A: Seniors don't use Medicare.Gov: how do eligible beneficiaries obtain information about Medicare Advantage Plans in the United States?. BMC Health Serv Res 21, 146 (February 2021): https://doi.org/10.1186/s12913-021-06135-7
[54] Shupei Yuan, Syed A. Hussain, Kayla D. Hales & Shelia R. Cotton: What do they like? Communication preferences and patterns of older adults in the United States: The role of technology, Educational Gerontology, 42:3, 163-174, (2016): https://doi.org/10.1080/03601277.2015.1083392

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

sales more difficult and create an additional burden for consumers who want to decide during a face-to-face interaction.

Exacerbating Health Inequity

We have found that many sub-demographics of older adults prefer face-to-face interactions, and these interactions are especially critical for people dually eligible for Medicaid and Medicare. A larger share of dually eligible older adults enrolls through face-to-face encounters given their lower level of access to, and familiarity with, technology. Creating barriers to face-to-face sales would work against efforts to advance health equity because of dually eligible beneficiaries' heavy reliance on and preference for face-to-face interactions, which allows them to pick the best plan for their personal needs and preferences.

Increasing Disenrollments

Elevance Health is aligned with CMS' efforts to reduce disenrollments and churn that can delay and interrupt patient care and increase administrative costs. In our review of disenrollments by source of enrollment, we have found that those who enroll as part of face-to-face interactions exhibit the least proportion of disenrollments as compared to beneficiaries who enroll through other sources. Given that a quality measure for health plans is disenrollments, face-to-face interactions should be encouraged, not discouraged, as would be the effect of the proposed regulation.

Increasing Complaints

Elevance Health is focused on limiting and addressing beneficiary complaints to the largest extent possible. In our review comparing beneficiary complaints to source of enrollment, we found that beneficiary complaints are lowest among the cohort of beneficiaries that enrolls following a face-to-face sales interaction. This supports evidence in other areas that demonstrates beneficiaries feel they receive the best information in face-to-face interactions, and those interactions should be encouraged instead of discouraged, as would be the case if these proposed provisions go into effect.

48-Hour Wait Time between SOA Being Filled Out and the Appointment

CMS proposes to prohibit personal marketing appointments from taking place until after 48 hours have passed since the time the beneficiary completed the SOA. Creating an arbitrary delay when a consumer is ready to have a sales conversation would create an unnecessary burden to enrollment. This proposal would result in the following:

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

- **Exacerbating health equity challenges:** As stated above, dual eligible beneficiaries have a higher share of enrollments through face-to-face encounters. These beneficiaries typically have less time to spend on Medicare enrollment and lower access to transportation and technology, making face-to-face interaction critical to ensure the beneficiary gets all of the information they need in a single interaction. Adding an arbitrary 48-hour wait time for beneficiaries earning low incomes would effectively require individuals to allocate additional time and find transportation for a second interaction, making it less likely beneficiaries would be able to enroll in the plan that best meets their personal needs and preferences.
- **Gaps in coverage:** Approximately 25% of beneficiaries wait until the last 7 days of open enrollment to have a sales conversation and enroll in coverage. This already creates a workload challenge with sales agents working as hard as possible to ensure those seeking to enroll at the last-minute do so with the best and most complete information possible. Many beneficiaries would not be aware of the mandated 48-hour waiting period, and if they fill out the SOA within the last few days the enrollment period, they will likely not have an opportunity to enroll, creating a gap in coverage and worse outcomes for the beneficiary. This dynamic would also increase beneficiary complaints as abrasion is created by the proposed arbitrary 48-hour waiting period
- **Higher numbers of disenrollments:** As explained above, face-to-face interactions exhibit the least proportion of disenrollments as compared to all other forms of marketing conversations. A large share of beneficiaries find they receive the best information in face-to-face encounters and enroll in the plan that best meets their personal needs and preferences. A 48-hour wait time would result in a lower proportion of sales occurring during face-to-face interactions, instead occurring through other mechanisms that exhibit higher proportions of disenrollments. In addition, a forced delay makes information learned during the initial interaction less fresh in the beneficiary's mind,[55] which could create additional confusion, challenges, and an increase in complaints. Furthermore, this proposal could result in more sales events and less educational events, which would make the beneficiary less informed overall and increase the chances of them enrolling in a plan that does not fit their unique needs.
- **Increasing complaints:** As explained above, the cohort of beneficiaries enrolling following a face-to-face sales interaction exhibits the highest level of satisfaction and fewest complaints. Creating a 48-hour wait time between the SOA being filled out and the appointment would result in fewer face-to-face sales interactions and CMS would see an

[55] Murman DL. The Impact of Age on Cognition. Semin Hear. (August 2015) ;36(3):111-21.: https://ncbi.nlm.nih.gov/pmc/articles/PMC4906299/

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

increase in beneficiary complaints as beneficiaries shift to other sales interactions that are not face-to-face where beneficiaries exhibit a higher proportion of complaints.

Recommendation: Elevance Health recommends CMS withdraw its proposal to prohibit personal marketing appointments from taking place until after 48 hours have passed since the time the beneficiary completed the SOA. Withdrawing this proposal would help avoid exacerbating health equity challenges, increasing disenrollments, and increasing beneficiary complaints. If a 48-hour wait time were put into place, health plans will need direction on the potential removal of the SOA from enrollment kits. Instead of prohibiting *certain types of sales interactions*, we urge CMS to instead focus on:

- Targeting the bad actors using its existing authority as outlined above. Such an approach would help ensure beneficiaries have maximum opportunity for face-to-face interactions, which yields the best results; and,
- Focusing on other elements such as the pre-enrollment checklist to ensure beneficiaries receive information in key areas, irrespective of the timing or type of sales interaction.

Separating Sales Events from Educational Events

CMS proposes to reinstate the prohibition on accepting SOA cards or the collection of beneficiary contact information at educational events. This includes a proposal to prohibit marketing events from taking place within 12 hours of the educational event in the same location.

Creating separation between marketing events and sales events would result in a similar set of challenges as the 48-hour wait time described above. Sales events that occur following educational events exhibit a remarkably high level of success in terms of beneficiary satisfaction and few disenrollments. Beneficiaries obtain information at the educational event, putting them a strong frame-of-mind to meet with a sales agent to further discuss options and potentially make an enrollment decision that is best for their circumstances and health needs.

Additionally, several national surveys indicate that older adults often face transportation issues, including inadequate access to transportation services, therefore, forcing a beneficiary to travel multiple times to the same location will add to the transportation burden they might

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

already be experiencing.[56] [57] We further note that we do not believe that offering food at educational events exerts pressures over beneficiaries to also attend a marketing event at the same location.

Separating sales events from educational events would create the following negative outcomes:

- **Exacerbating health equity challenges:** As previously detailed, dual eligible beneficiaries exhibit a higher share of enrollments through face-to-face encounters. Dually eligible beneficiaries typically have less time to focus on Medicare enrollment and exhibit lower access to transportation and technology that makes each engagement critical to ensure the beneficiary gets all the information needed in that one block of time and location. Separating sales events from educational events would create a barrier for beneficiaries earning low incomes who want to have a face-to-face sales interaction, which would have the effect of requiring those beneficiaries to allocate additional time and find transportation for a second interaction, making it less likely beneficiaries earning low incomes would be able to enroll in the plan that best meets their needs.
- **Exacerbating disenrollments:** As previously detailed, face-to-face interactions exhibit the least proportion of disenrollments as compared to all other forms of marketing conversations. A large share of beneficiaries find they receive the best information in face-to-face encounters and enroll in the best plan that meets their needs. Separating sales events from educational events would result in a fewer proportion of sales occurring during face-to-face interactions, instead occurring through other mechanisms that exhibit higher proportions of disenrollments.
- **Increasing complaints:** As previously detailed, the cohort of beneficiaries enrolling following a face-to-face sales interaction exhibits the highest level of satisfaction and fewest complaints. Separating sales events from educational events would result in fewer face-to-face sales interactions and CMS would see an increase in beneficiary complaints as beneficiaries shift to other sales interactions that are not face-to-face where beneficiaries exhibit a higher proportion of complaints.

Recommendation: Elevance Health recommends CMS withdraw its proposals related to separating sales events from educational events. Withdrawing this proposal would help avoid exacerbating health equity challenges, increasing disenrollments, and increasing beneficiary complaints, as would be the case by creating barriers to face-to-face sales

[56] National Association of Area Agencies on Aging Website: *National Association of Area Agencies on Aging Annual Report* (accessed January 2023): usaging.org
[57] National Aging and Disability Transportation Center Website: *Survey of Organizations that Provide Transportation Services to Older Adults and People with Disabilities* (accessed January 2023): nadtc.org https://www.nadtc.org/wp-content/uploads/KRC-NADTC-Survey-Report-11May2020.pdf

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

interactions. Instead of prohibiting or inhibiting certain types of sales interactions, we urge CMS to instead focus on:

- **Targeting the bad actors** using its existing authority as outlined above; and,
- **Focusing on other elements such as the pre-enrollment checklist** to ensure beneficiaries receive information in key areas, irrespective of the type of sales interaction.

Length of Time an SOA or Business Reply Card (BRC) is Valid

CMS proposes to limit the validity of SOAs and BRCs to six months from the beneficiary's signature date. Elevance Health supports CMS' intent to ensure marketing stakeholders cannot use SOAs or BRCs as an *unlimited* source of a marketing lead with no end date. However, we would suggest a limitation of 11 months to ensure any preliminary conversations that take place during the year can be followed-up for the next open enrollment. For example, if an initial conversation takes place in February, and the beneficiary would like to follow-up during the next open enrollment period, the SOA/BRC should still be valid during the next open enrollment period. In those situations, limiting the SOA and BRC to six months would create unnecessary follow-up.

Recommendation: Elevance Health requests CMS modify this proposal to limit the validity of SOAs/BRCs to 11 months (instead of 6 months) to ensure SOAs and BRCs can always be valid for the next open enrollment.

Improper Use of Terms and Logos

Elevance Health supports prohibiting any marketing entities from using government terms and logos in a way that implies to consumers the entity is representing the government, or otherwise misusing government terms and logos. However, CMS' proposal is not clear enough on what would be permissible.

For example, even using the term "Medicare Advantage" could be considered an improper use of a government term. Bad actors may take advantage of such a lack of clarity, while making legitimate and beneficial activities more difficult for good actors.

Recommendation: If CMS finalizes this proposal, Elevance Health requests CMS make this provision extremely clear, with a large number of examples of what is permissible versus what

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

is not permissible. Such specificity would not just help stakeholders, but also CMS' regional offices that respond to questions and perform enforcement.

Identifying the Name of the Organization/Marketing Name in Advertising

Elevance Health supports CMS' objective to ensure consumers must not be misled by marketing materials and must be able to understand what is being sold. However, we believe CMS' proposed requirement—to identify the name of the organization or marketing name of all plans being sold—would likely serve to confuse beneficiaries more than it would add value. This perspective is based upon the fact that much Medicare marketing involves selling a large number of plans and including all the names in materials would result in a "sea of names" in many instances.

Recommendation: Elevance Health recommends CMS withdraw this proposal to avoid increasing the complexity of marketing materials in a way that may provide more confusion than value to beneficiaries.

Summary of Benefits in MA Model Materials

CMS proposes that the Summary of Benefits be included in the top half of the first page and in the order currently listed in 422.2267(e)(5)(ii)(A)(1) through (10).

Recommendation: Elevance Health requests clarification on the meaning of to "…be included in the top half of the first page…." Our Summary of Benefits follows guidance for required medical benefits and order of information, so clarification and an example of what type of document this provision applies to and the requirements would be beneficial to understand the proposed guidance.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Mental Health and Substance Use Disorders (MH/SUD)

Network Adequacy Standards for MH/SUD Providers

The U.S. is continuing to experience a dramatic increase in MH/SUD needs (described as behavioral health in proposed rule) in the wake of the COVID- 19 pandemic. During this time, Elevance Health (including our behavioral health management subsidiary, Beacon Health Options) has demonstrated a strong commitment to improving the mental health of our members and has continued to support laws and regulations to ensure equity between MH/SUD and medical benefits. As part of our efforts to listen to those on the front lines and offer our own data to help inform MH/SUD solutions, we recently released a report entitled *State of the Nation's Mental Health,*[58] which is based on an analysis of more than 27 million healthcare claims and a nationwide clinician survey. The survey concluded nearly 75% of mental health specialists estimate mental health repercussions from the pandemic will last three years or more.

This persistent increase in demand has outpaced the supply of MH/SUD professionals.[59] The GAO's October 2022 report[60] on MH/SUD workforce included the following conclusions:

- Approximately half of counties in the U.S. did not have an active psychiatrist or addiction medicine specialist;
- More than 150 million people live in federally designated mental health professional shortage areas; and,
- In the near future, the U.S. will be short between 14,280 and 31,109 mental health providers.

A November 2022 report from the American Psychological Association[61] reinforces the fact that demand for MH/SUD services exceeds the supply of MH/SUD professionals. Nearly half of 2,300 psychologists surveyed said they were unable to meet demand for treatment, while 60% have no more openings for new patients, and 42% have waitlists of at least 10 patients. To

[58] *Anthem's (now Elevance Health) State of the Nation's Mental Health*. May 2021. https://www.stateofthenationsmentalhealth.com
[59] https://www.modernhealthcare.com/labor/aamc-primary-care-mental-health-physician-shirtage-backlogs?utm_source=modern-healthcare-am-wednesday&utm_medium=email&utm_campaign=20230117&utm_content=article1-headline
[60] *Behavioral Health: Available Workforce Information and Federal Actions to Help Recruit and Retain Providers.* Government Accountability Office. October 21, 2022. https://www.gao.gov/products/gao-23-105250
[61] Psychologists Struggle to Meet Demand Amid Mental Health Crisis. American Psychological Association. November 2022. Available at https://www.apa.org/pubs/reports/practitioner/2022-covid-psychologist-workload.pdf

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

address this increase in demand for MH/SUD services amid a workforce shortage, Elevance Health has implemented several initiatives to best address the needs of beneficiaries, including utilizing peer support specialists (individuals with lived experience of MH/SUD conditions) and providing expanded telehealth options.

Congress began working to address the shortage of MH/SUD professionals in the Consolidated Appropriations Act, 2023 (CAA; also known as the 2023 Omnibus Appropriation bill) signed into law on December 29, 2022. The bill provides a meaningful expansion of access for Medicare beneficiaries by adding coverage for intensive outpatient mental health programs and care provided by marriage and family therapists and mental health counselors. It also increases reimbursement provided via mobile crisis care units and funds additional graduate medical education training positions, half of which must be reserved for psychiatry specialties.

Despite these efforts, a major challenge for all stakeholders is—foundationally—there are currently not enough MH/SUD providers in the U.S. As an alternative, Elevance Health supports policymaker efforts to increase the supply of MH/SUD providers over time to better meet increasing demand. This includes:

- Allowing peer support specialists to be eligible for Medicare reimbursement;
- Expanding the types of services and providers eligible to receive federal/state funds. For example, payment of asynchronous care, coaching, texting, and wellness services should be evaluated;
- Examining scope of practice/physician oversight/supervision rules to increase access to a broad array of providers and services and to further support opportunities for providers to practice at the top of their level of licensure;
- Increasing funding for graduate medical education programs specifically designated for MH/SUD providers; and,
- Working with CMS and other stakeholders to develop a comprehensive strategy to address the shortfall of MH/SUD providers.

Addition of Specialty Types Subject to Network Adequacy: MOUD

CMS proposes to add three MH/SUD specialty types to network adequacy regulation, clinical psychology, clinical social work, and prescribers of Medications of Opioid Use Disorder (MOUD). As outlined above, Elevance Health supports CMS' efforts to maximize beneficiary access to MH/SUD providers, including prescribers of MOUD. The prescribing of MOUD is an area that is quickly evolving, particularly with the recent enactment of Section 1262 of the 2023

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

CAA, which removed the federal requirement for practitioners to submit a Notice of Intent (that is, have a waiver commonly referred to as an "X-Waiver") to prescribe medications, like buprenorphine, for the treatment of opioid use disorder.

Given that all licensed practitioners can now prescribe MOUD, it is incongruous to have a specific network adequacy test for MOUD prescribers. The network adequacy test could essentially be attached to all licensed prescribers.

Recommendation: Elevance Health recommends CMS withdraw the proposal to add prescribers of MOUD as a specialty type to network adequacy requirements, as it is incongruous with the 2023 CAA, and the expansion of MOUD prescribers. CMS should allow the impact of the CAA to take effect before considering additional regulation related to MOUD.

Appointment Wait Time Standards

CMS proposes to codify primary care appointment wait time standards from existing sub-regulatory guidance and to extend those standards to MH/SUD services. While Elevance Health supports CMS' efforts to ensure beneficiaries do not have a significant wait for key services, there are many variables that make it challenging to precisely track and adhere to wait times. CMS does not have a reasonable and efficient framework for assessing appointment availability, and existing audits do not generate objective, consistent outcomes that would generate proof of compliance. This lack of a workable framework—amid the national shortage of MH/SUD providers described above—creates substantial uncertainty for health plans, exacerbating the likelihood that health plans could curtail offerings and consumer choice.

Health plans also need time to collaborate with providers to develop a reporting system that allows health plans to collect appointment wait time data. FHIR is the industry interoperability standard that allows health data, including clinical and administrative data, to be quickly and efficiently exchanged between entities. Currently, appointment scheduling information cannot be included in the FHIR record. Any attempt to implement new appointment wait time standards without a reporting system that is workable for both health plans and providers, including modifications to the FHIR standard so that appointment scheduling information can be included in the FHIR record, would lead to significant provider abrasion, discouraging provider participation in plan networks.

Recommendation: Because of these challenges and negative implications for beneficiaries, we recommend CMS:

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

- **Add flexibility to any new MH/SUD network adequacy standards**: We recommend CMS provide flexibility for any additional network adequacy justifications that would account for the fact that these standards would be new and implemented during a MH/SUD provider shortage.
- **Reconsider stringent wait time standards**: Wait times cannot be perfectly measured and are enforced using audits that do not generate perfect, objective results. Given the MH/SUD provider shortage, such audits would generate inconsistent results and needlessly increase administrative costs that would be passed on to beneficiaries. Instead, we encourage CMS to reconsider the wait time standards and work with stakeholders on accurately measuring and implementing such standards with appropriate flexibilities to avoid provider abrasion that could discourage participation with MA plans.
- **Help address the MH/SUD provider shortfall**: We request CMS work collaboratively with stakeholders to develop a comprehensive strategy to address the shortfall of MH/SUD providers.

If CMS is intent on moving forward with new wait time standards, we request CMS delay the implementation of such standards until FHIR standards can be updated to help create a more efficient and effective way of demonstrating compliance.

Provider Contract Termination Notification Requirements (Non-MH/SUD and Primary Care)

For provider terminations that are not MH/SUD or primary care, CMS proposes to split beneficiary notification requirements based on two types of provider terminations. For provider terminations with cause, CMS proposes to maintain its "good faith effort" standard for timely notification to beneficiaries. For provider terminations without cause, CMS proposes to remove its "good faith effort" standard since the timeline for notification should be within health plan control to provide notice.

Elevance Health is aligned with CMS' goal to ensure beneficiaries are notified expeditiously when it is clear that a provider is leaving the network, and we support the general concept of this proposed requirement. However, as it relates to provider terminations without cause, it is common that the provider is the party that is initiating the termination, and we do not always receive sufficient notice from the provider to meet CMS' timeframes for beneficiary notification. If this provision were to go into effect, CMS' auditors would find cases where a health plan does not meet the notification timeframes because of untimely notification from providers—not an action from the health plan itself—resulting in administrative confusion

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

and unreasonable increased administrative costs that would be passed on to beneficiaries in the form of higher premiums and/or reduced benefits.

Recommendation: Elevance Health requests CMS modify its proposal such that the "good faith" standard remains in effect if the provider (instead of the health plan) is the party terminating the contract. This would avoid administrative confusion with CMS' auditors that would lead to unreasonable administrative costs that would be passed on to beneficiaries in the form of higher premiums and/or reduced benefits.

Provider Contract Termination (MH/SUD and Primary Care): Extending Notification Irrespective of When a Beneficiary Last Saw the Provider

For MH/SUD and primary care providers, CMS proposes to expand the scope of notification requirements to ALL beneficiaries who have ever been patients of a terminating primary care provider (not just those who are patients seen on a regular basis by the terminating provider, which is the notice applicability for all other specialty types).

Elevance Health supports CMS' objective to ensure beneficiaries receive timely notices of contract terminations for all providers for which beneficiaries have a relatively recent—and therefore potentially ongoing—relationship. It is important that beneficiaries know when a provider with which they have an ongoing relationship is leaving the network so that they can make any adjustments to meet their needs.

Because beneficiaries already receive a significant number of notices from their health plan, it is important to consider whether any new notification requirements are important relative to existing requirements because any additional notifications will dilute the impact of all notices, making the beneficiary less likely to pay attention to important notices. Requiring health plans to notify beneficiaries about providers leaving the network they saw in the past—with an unlimited lookback—would cause abrasion and dilute the impact of important notices. For example, if a beneficiary receives a notice about a provider they have not seen in many years and do not have any plans to see that provider in the future, they will not find value in that notice, and may begin to assume that future notifications do not have value.

Additionally, while CMS asserts in this proposed regulation that MH/SUD and primary care providers are especially critical in terms of relationships with the beneficiary and should be

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

treated more intensely from a notification perspective, the same could be asserted for other provider types that are particularly important to each beneficiary.

Recommendation: Elevance Health recommends CMS withdraw this proposal and leave in place existing regulatory requirements that require health plans to notify beneficiaries who are patients seen on a regular basis by the terminating provider. Withdrawing this proposal will avoid beneficiary confusion and abrasion.

Provider Contract Termination (MH/SUD and Primary Care): Requiring Telephonic Notification

CMS also proposes to require both written and telephonic notice for contract terminations that involve a primary care or MH/SUD provider (instead of just written notice). Elevance Health supports CMS' efforts to ensure beneficiaries receive timely notices of contract terminations for all providers for which beneficiaries have a relatively recent—and therefore likely ongoing—relationship. However, we do not believe telephonic outreach would help reach this goal.

Our Medicare MH/SUD case managers who perform telephonic outreach only successfully talk with the beneficiary 36% of the time, largely due to beneficiaries not wanting to receive phone calls.

As stated above, health plans are already required to notify beneficiaries by mail who are patients seen on a regular basis by the terminating provider. We believe this is the appropriate standard and would be the preference of beneficiaries for this specific circumstance.

Recommendation: Elevance Health recommends CMS withdraw this proposal and leave in place existing regulatory requirements that require health plans to notify beneficiaries by mail. Withdrawing this proposal will avoid beneficiary confusion and support clear communication.

Additional Provider Directory Elements for Providers Offering MOUD

CMS proposes to add a new provider directory data element showing certain providers who offer MOUD. Elevance Health supports CMS' efforts to ensure beneficiaries can access—and

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

easily identify—providers offering MOUD. As stated above, this is an area that is quickly evolving, particularly with the recent enactment of the 2023 CAA, which removed the federal requirement for practitioners to submit a Notice of Intent (that is, have a waiver commonly referred to as an "X-Waiver") to prescribe medications, like buprenorphine, for the treatment of opioid use disorder.

As all licensed practitioners can now prescribe MOUD, there is no longer a need to have a data element in provider directories showing which providers offer MOUD. Such a data element could potentially be attached to all relevant practitioners, removing any value from adding the element.

Given that any provider can now prescribe MOUD, the source of truth for this data is in question, and we do not yet have the ability to validate the accuracy of this data. Therefore, we encourage CMS to withdraw this proposal until data can be appropriately gathered and accurately validated.

Recommendation: Elevance Health recommends CMS withdraw this proposal, as it is no longer necessary due to the enactment of the 2023 CAA.

Requiring Non-Renewal Notices as Standard Communication Material

CMS proposes that the non-renewal notice be a model communications material. Model materials are required content created by CMS as an example of how to convey beneficiary information.

Recommendation: Elevance Health supports this proposed change, but we request CMS clarify how it intends to provide "equal prominence" to all healthcare choices within the Non-Renewal and Service Area Reduction (NR/SAR) notice prior to the model release. The NR/SAR model notices are generally released close to the required in-home date, and we have concerns about the timeline should there be changes to how alternative healthcare options are required to be displayed.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Opt-Outs for Plan Marketing

CMS proposes to require each MA organization and Part D plan sponsor to provide the opt-out information to all beneficiaries, regardless of plan intention to contact, at least annually in writing.

Recommendation: Elevance Health supports this proposed change, but we urge CMS to allow for the addition of the opt-out information in a standard model material. While CMS suggests that the opt-out can be included in the welcome packet, that packet is not provided to all beneficiaries annually. A separate mailer would need to be provided to beneficiaries unless CMS allows health plans to include the opt-out language as part of its model material. This approach would help limit administrative costs, which would otherwise be passed on to beneficiaries, and environmental waste.

***

We value the partnership that we have developed with CMS and welcome the opportunity to discuss our recommendations. Should you have any questions or wish to discuss our comments further, please contact Danielle Horne at (818) 298-7830 or danielle.horne@elevancehealth.com.

Sincerely,

Elizabeth P. Hall
Vice President, Public Policy and Issues Management, Elevance Health

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

Appendix I: Part C and D Star Ratings Tukey Outlier Deletion Simulations

Upon reviewing the simulations provided by CMS, we have several observations which raise concerns about the applicability of the Tukey Outlier Deletion to the Star Ratings methodology.

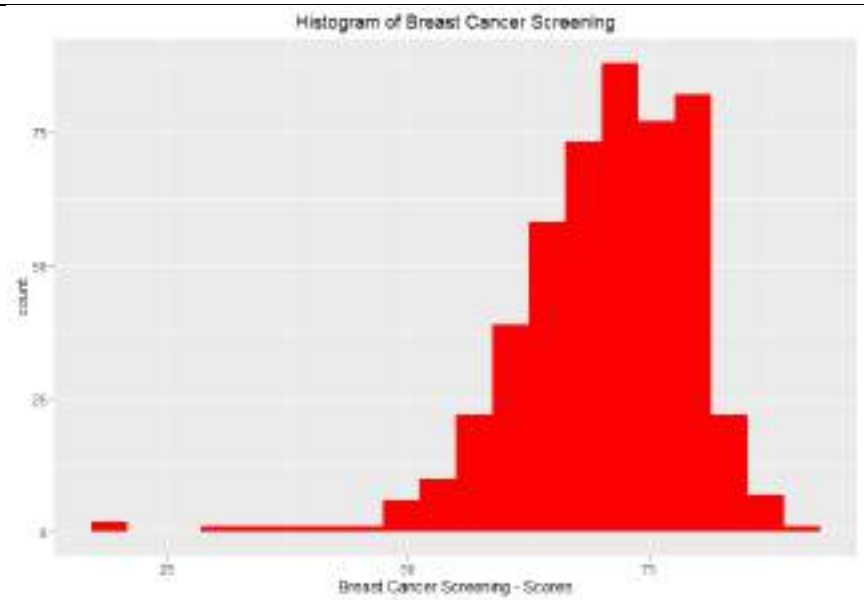
1. There were multiple instances where the lower outlier cutoff is 0 and or the upper outlier cutoff is 100.
   a. As described within the Technical Notes document, "If the calculated outlier cutoff is below the minimum or exceeds the maximum value for the given measure, then the minimum or maximum value is displayed as the cutoff." Interpreting this method with a hypothetical example, in a set of values for a given measure that range from 14 to 92, if the lower outlier cutoff is 10, then the cutoff to be used would be 14, or if the upper cutoff is 95, then the cutoff to use would be 92.
   b. We have revised the 2022 and 2023 Report Card Master Table for actual measure score results, along with Tukey Outlier simulations. An exercise was completed trying to come up with an approximation for the Breast Cancer Screening measure for Star Rating year 2023. Using the statistical description to obtain the quartiles and other parameters, the upper fence that we obtain with the data available is 90, which is the highest value obtained in 2023. However, the Upper Outlier Cutoff defined by CMS for this measure in 2023 is 100. Even if calculation differences were resulting from the mean resampling, there are no values above 90 in the data set that justify the upper cutoff of 100. This is equivalent to determining that there are no outliers, which calls the current methodology into question.

From the summary statistics, we can calculate the median, first quartile (25th percentile), third quartile (75th percentile), upper and lower whiskers also known as inner and outer Tukey fences.

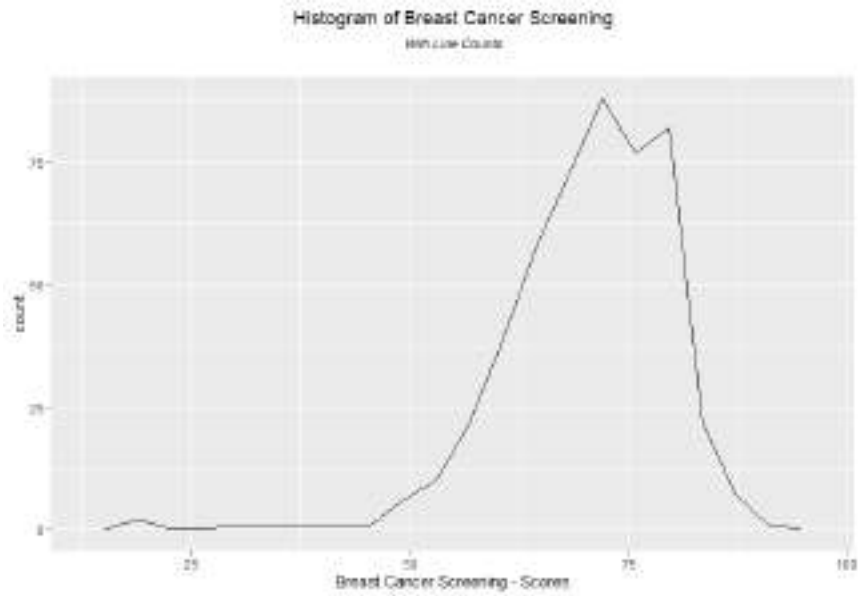
```
> summary (BCS_2023)
Breast Cancer
Min. : 18.00
1st Qu.: 66.00
Median : 72.00
Mean : 70.39
3rd Qu.: 77.00
Max. : 90.00
```

From the output, we see the minimum score is 18%, while the maximum performance execution is 90%. Therefore, the range between max - min is 72. This may suggest variability.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

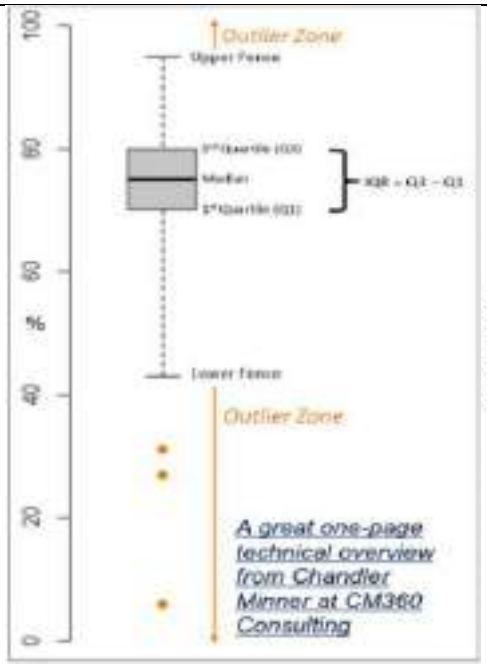


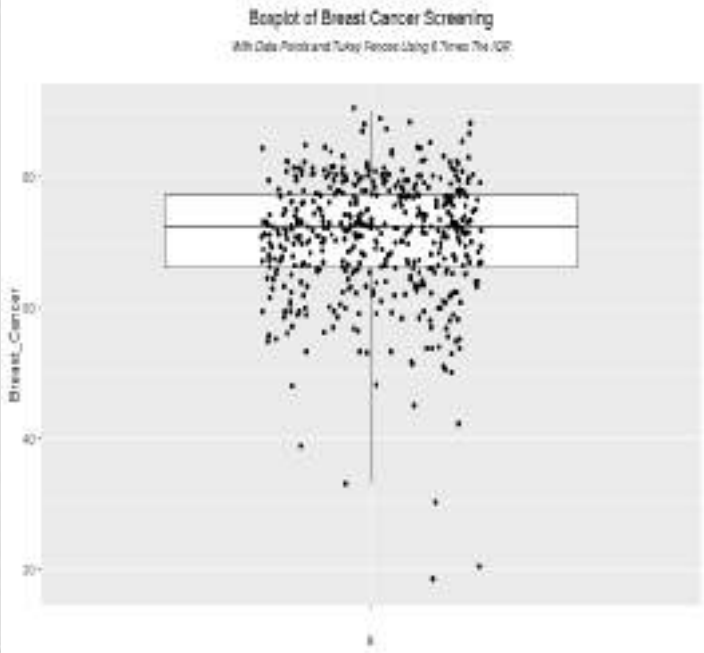
Most of the values are on the right side of the histogram, with fewer values spread along the left tail. In addition, the plot reveals the presence of outliers in the lower left side of the plot.



The breast cancer measure scores are negatively skewed. In a negative skew, the left tail is longer, with observations stretching and spreading along the tail. Similarly, data points are clustered on the right side, proving the asymmetric distribution of the values of the variable. The mean and the median occur at different points, though the difference is small.

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004



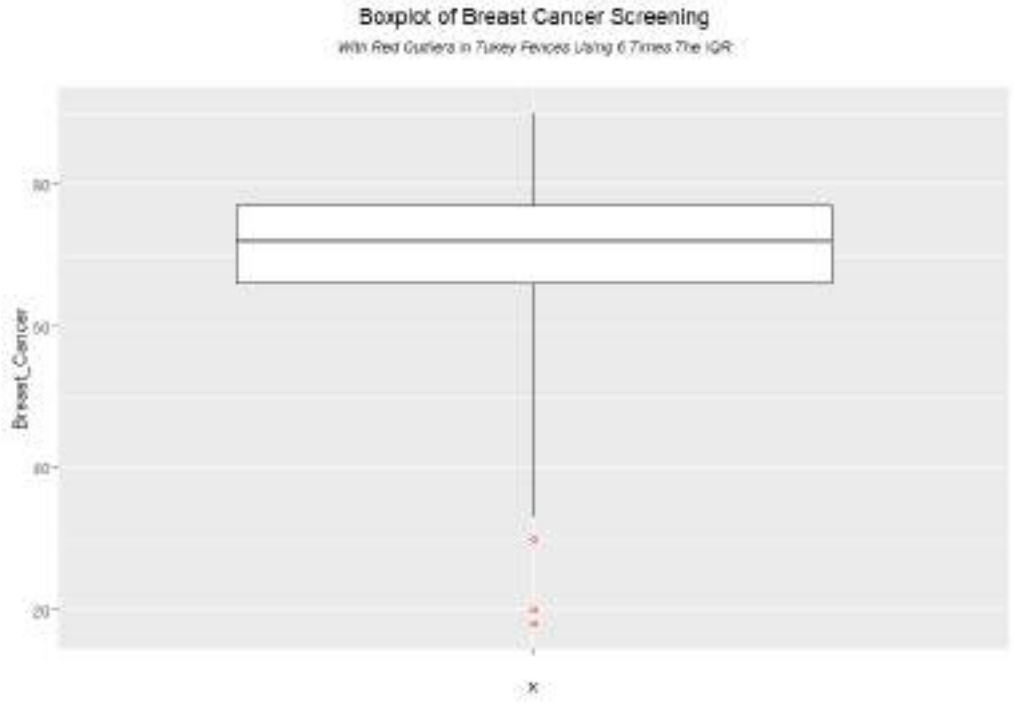


Technical Notes for Star Ratings Tukey Outlier Deletion Simulations:

*"These simulations include identification of Tukey outer fence outliers which are defined as measure scores that are below a certain point (first quartile–**3.0** × (third quartile–first quartile)) or above a certain point (third quartile + **3.0** × (third quartile–first quartile))."*

"If the calculated outlier cutoff is below the minimum or exceeds the maximum value for the given measure, then the minimum or maximum value is displayed as the cutoff."

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004



CalculatedLowerInnerFence = 66- 3*(77-66) = 33 > minimum score (18) , then cutoff = 33
CalculatedUpperInnerFence = 77+3* (77-66) = 110 > maximum value (90), then cutoff = 90

In the results, the output displays 3 values that are below the lower Tukey fence. These are values below 33%.

c. From the histogram above, we can also conclude that for this measure, there is a negative skew on these scores which results in a distribution far from normal, not indicated for use in the Tukey Outlier Deletion process.

d. One other example to review is the Osteoporosis Management in Women Who Had a Fracture measure, with a range of values for 2023 between 14 and 92, with a cutoff of 0 and 100. There are several instances where the lower outlier cutoff is lower than the minimum value observed, such as Reducing the Risk of Falling, Improving Bladder Control, and Medication Reconciliation Post Discharge.

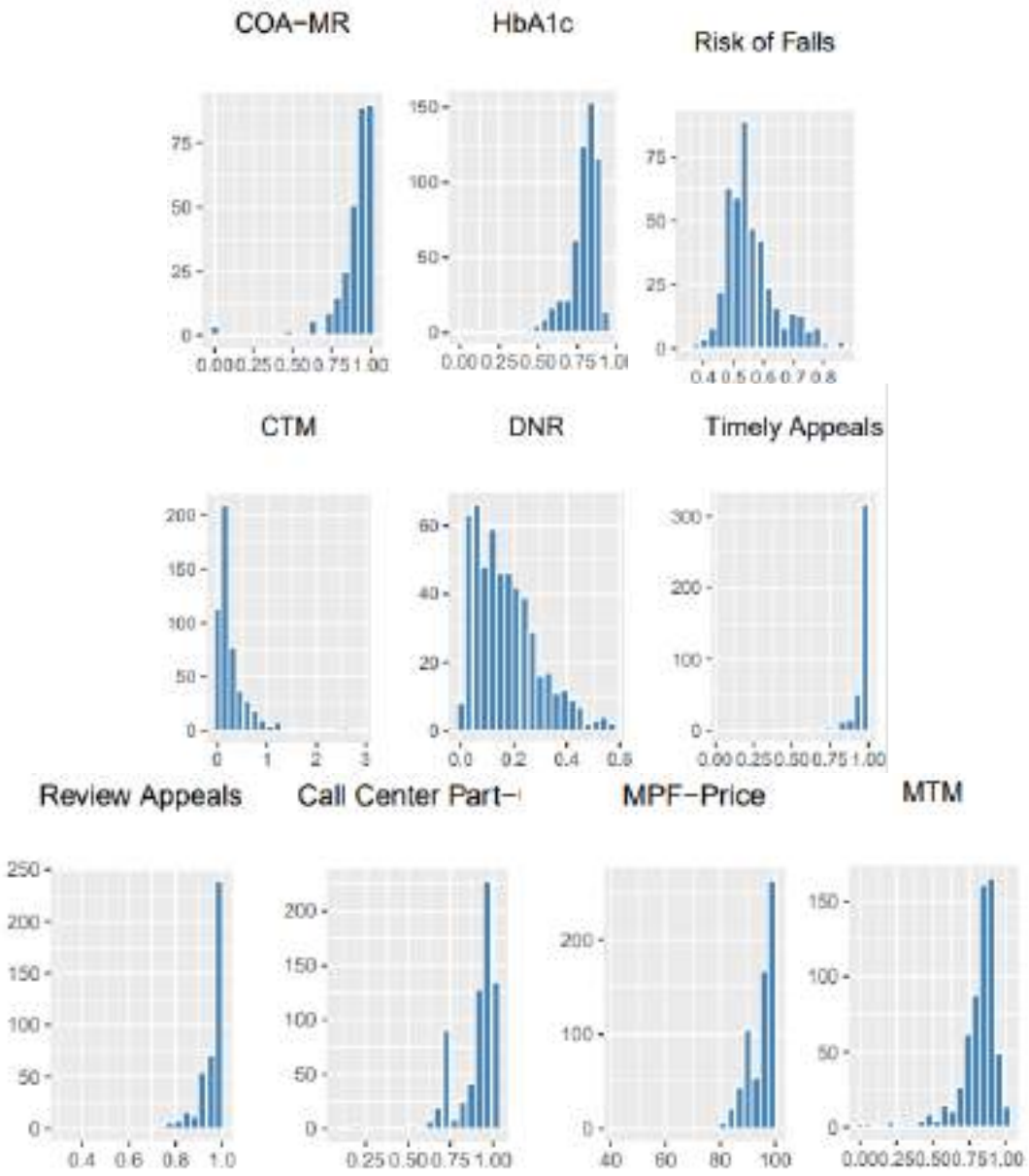
2. We are concerned about significantly different cut points once the Tukey outlier deletion is applied, with several measures experiencing differences greater than 5 percentage points, which from a guardrail perspective was identified as a reasonable difference cap year-over-year. In some circumstances, differences are up to 30 percentage points such as the case of Care for the Older Adult – Medication Review measure. This is an impactful change that would be administered on a single year. We have simulated what would have been the actual distribution of contracts per rating level for Star Ratings Year 2023 had the simulated cut points been utilized; they would depart from the public Part C and Part D performance data showing the scores of each contract at the individual measure level. We have reinterpreted Star Ratings based upon the simulated cut-points resulting in only 5% of enrollees among MA-PD contracts in 5-Star plans as opposed to the reported

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004

21.87%. A significant shift was also observed in the volume of enrollees in 3.5-Star contracts moving from 18.71% to a simulated 25.4%.

3. HOS measures, however, tend to remain unchanged, and differences for PDP only cut points seem to be stable, likely because of a lower set of scores being evaluated, which calls into question the purpose of the methodology.
4. This is the first-time contracts are given the opportunity to fully explore the impact of this method in the calculation of cut points, and such simulations are based upon measurement years 2020 and 2021, for which Extreme and Uncontrollable circumstances were in place, which have potentially impacted the analysis.
5. Contracts do not have a way to properly review cutoffs or cut points because not all contracts' scores considered are public (that is, rescinded contracts).
6. The methodology does not consider the size of outliers, particularly on the upper cutoff, where smaller contracts may be better positioned to achieve better performance.
7. Many of the measures under the Star Rating methodology do not follow a normal distribution pattern as shown in the histograms below, based on Star Ratings Year 2023 scores:

Elizabeth P. Hall, Vice President, Public Policy and Issues Management
1001 Pennsylvania Avenue, NW, Suite 710, Washington, DC 20004


COA−MR
HbA1c
Risk of Falls
CTM
DNR
Timely Appeals
Review Appeals
Call Center Part−
MPF−Price
MTM

TAB 18

As of: March 04, 2024
Received: February 13, 2023
Status: Posted
Posted: February 17, 2023
Category: Physician - HC005
Tracking No. le3-by3h-xoqd
Comments Due: February 13, 2023
Submission Type: API

PUBLIC SUBMISSION

Docket: CMS-2022-0191
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024

Comment On: CMS-2022-0191-0001
Medicare Program: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, etc.

Document: CMS-2022-0191-0743
Comment on CMS-2022-0191-0001

Submitter Information

Email: lsola@villagemd.com
Organization: VillageMD

General Comment

Please see attached document for comment.

Attachments

VillageMD Part CD Response_20230213_FINAL

VillageMD

February 13, 2023

Chiquita Brooks-LaSure
Administrator
Center for Medicare & Medicaid Services
Department of Health and Human Services
Attention: Medicare Advantage RFI
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; Contract Year 2024 Policy and Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Program for All-Inclusive Care for the Elderly; Health Information Standards and Implementation Specifications

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to assist the Center for Medicare & Medicaid Services in strengthening Medicare Advantage.

About VillageMD
VillageMD was founded with a bold principle: changing primary care in the United States so that our country can be the global leader in health outcomes regardless of background and income. Through its subsidiary Village Medical, VillageMD is a leading provider of value-based primary care services. Village Medical provides primary care for patients at traditional free-standing practices, Village Medical at Walgreens practices, at home and via virtual visits. The VillageMD clinical model spans the spectrum of care, from disease prevention through timely interventions such as immunizations and lifestyle modification, to managing and treating disease conditions. We achieve this by working within the "medical neighborhood," building effective partnerships for all levels of care.

A commitment to health equity underlies VillageMD's organization and clinical model. VillageMD operates in 26 markets with 680 locations. Over the next five to ten years, Village Medical and Walgreens will establish 1,000 Village Medical at Walgreens primary care practices in more than 30 U.S. markets, more than half in which will be in medically underserved communities. These clinics will be deeply embedded in the communities they serve: they will provide care to those living within the community, hire care team members that are reflective of their community, and create healthcare jobs with upward mobility. In addition, locating Village Medical at Walgreens allows for primary care physicians and pharmacists to collaborate to create a more coordinated care approach and integrated patient experience. VillageMD currently contracts across all payer types, including Medicare Advantage, Traditional Medicare, commercial and Medicaid. With that in mind, we offer the following comments in regard to the quality components released in the Medicare Advantage program from Calendar Year 2024.

1. **Medication Reconciliation Post-Discharge:** Following NCQA's retirement of the medication reconciliation post discharge measure, CMS announced that medication reconciliation would roll

into the transitional care management measure. VillageMD applauds the administration for ensuring patients are receiving the care they need across the continuum of care, especially following a discharge from the hospital. However, we were anticipating that the measure would be phased out following the 2022 calendar year, but CMS just announced that it will be continuing through the end of calendar year 2023**.** *VillageMD urges the administration to retire the measure after calendar year 2022 to avoid double-weighing the impact transitional care management will have on quality performance.* This will make the implementation and removal process for the medication reconciliation measures less smooth.

2. **Medication Adherence Measures:** CMS has proposed to implement risk adjustment based on the PQA specifications of SDS characteristics (for age, gender, dual eligibility/LIS, and disability status), which would also be reflected in Star Ratings; further CMS would remove the medication adherence measures from the CAI adjustment. VillageMD appreciates CMS' work to ensure beneficiaries are adhering to their medication to optimize their clinical outcomes. We would appreciate additional clarification around the proposals because it was expected to have a more neutral impact but has been found to have a larger net negative impact than a net positive impact. *VillageMD recommends that CMS explore what is causing this and adjust the measures based on your findings.*
3. **Concurrent Use of Opioids and Benzodiazepines:** CMS has proposed a new measure to prevent drug-drug interactions that could be fatal, specifically the prescribing of both an opioid and benzodiazepine. VillageMD wholeheartedly supports the intention to measure polypharmacy issues, however, we have concerns that this measure would not measure fairly across geographic areas due to the regional variation in opioid usage across the USA. *We urge CMS to incorporate a regional adjustment to account for the well-documented*[1] *regional trends of opioid usage in the USA.*
4. **Cut Points:** CMS has proposed to eliminate the 5% guardrails on the cut point calculation starting in 2024. *VillageMD is supportive of the elimination of the guardrails, however, we recommend that it is phased out over 3 years to minimize the impact it has on STAR ratings during the initial year of guardrail elimination.* In the Tukey Outlier Simulation Output for Contract results shared by CMS in December 2022, we noted several instances of very large cut point adjustments (in excess of 15%), which suggests a three-year guardrail elimination timeline would allow for a more seamless implementation of the Tukey Outlier methodology.
5. **Health Equity Index Reward Program:** VillageMD is deeply supportive of incorporating health equity into the Medicare program as much as possible. We applaud CMS' continual focus on making health equity a reality in the US healthcare system. The Area Deprivation Index is a great start for measuring health disparities, however, there are shortcomings in the indexing that create a misrepresentation of underserved status, specifically in urban areas with higher home values. Due to this issue, VillageMD recommends that CMS continue to monitor different indices that measure socioeconomic status and adopt them if they are found to be a more accurate measure.

Thank you again for your commitment to strengthening our nation's Medicare system, and for thoughtful consideration of the issues and potential solutions we have raised. VillageMD is happy to be

[1] https://collections.nlm.nih.gov/catalog/nlm:nlmuid-101751557-pdf?_gl=1*1306m60*_ga*MTYzMzY0NTA2My4xNjc2MDU2NTU4*_ga_P1FPTH9PL4*MTY3NjA1NjU5MC4xLjEuMTY3NjA1NjYyMi4wLjAuMA..*_ga_7147EPK006*MTY3NjA1NjU5MC4xLjEuMTY3NjA1NjYyMi4wLjAuMA..

a resource for CMS as you further develop the Medicare program. If you have any questions or would like to set up a discussion, please reach out to Lucy Sola at LSola@VillageMD.com.

Sincerely,

Gary Jacobs, Executive Director of VillageMD Center for Government Relations and Public Policy
VillageMD

TAB 19

As of: March 04, 2024
Received: February 13, 2023
Status: Posted
Posted: February 17, 2023
Category: Health Plan or Association
Tracking No. le3-c1r1-fszz
Comments Due: February 13, 2023
Submission Type: API

PUBLIC SUBMISSION

Docket: CMS-2022-0191
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024

Comment On: CMS-2022-0191-0001
Medicare Program: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, etc.

Document: CMS-2022-0191-0750
Comment on CMS-2022-0191-0001

Submitter Information

Email: Jennifer.DeAngelis@blueshieldca.com
Organization: Blue Shield of California

General Comment

Attached please find Blue Shield of California's comment letter in response to the CY 2024 Medicare Advantage and Prescription Drug Benefit Program Policy and Technical Changes Proposed Rule (CMS-4201-P). If you have any questions, please contact Jennifer DeAngelis at Jennifer.DeAngelis@blueshieldca.com.

Attachments

Blue Shield of California_2024 MA Part D Policy PR Comment Letter FINAL

blue of california

February 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS–4201–P
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via http://www.regulations.gov

RE: CMS-4201-P; Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

Dear Administrator Brooks-LaSure:

Blue Shield of California (Blue Shield) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services's (CMS) Contract Year (CY) 2024 Policy and Technical Changes Proposed Rule. Blue Shield is a nonprofit health plan that offers health benefits coverage to individuals and groups throughout the State of California. Our mission is to ensure that all Californians have access to high-quality health care at an affordable price. Blue Shield is the parent organization of Blue Shield of California Promise Health Plan, and as such is providing comments on behalf of both organizations.

The CY 2024 Policy and Technical Changes Proposed Rule (CMS-4201-P) includes several proposals that would require extensive plan resources to implement. These proposals would layer on top of significant program changes that were finalized in prior CMS rulemaking and enacted in the Inflation Reduction Act, including the restructuring of the Part D benefit, as well as proposals in the CY 2024 Advance Notice that would revise the Part C risk adjustment model and other rulemaking, like the Advancing Interoperability and Improving Prior Authorization Proposed Rule (CMS-0057-P), that would impact the Medicare Advantage (MA) program.

As CMS assesses stakeholder comments and makes decisions about finalizing proposals in this rule, we strongly encourage CMS to consider the totality of the near-term changes facing MA plans and Part D sponsors and the administrative burden and costs associated with those changes. We request CMS finalize policies in a practical and sustainable manner that provides MA plans sufficient time to plan, garner resources for implementation, and ensure Medicare beneficiaries continue to receive high-quality care.

To that end, we request CMS consider the following priority recommendations:

- **Changes to the Part D Medication Therapy Management (MTM) Program**: We encourage CMS *not* to proceed with the proposed changes to the MTM Program's eligibility criteria due to cost impacts and implementation challenges.

- **Changes to marketing rules:** We request CMS delay the effective date for the proposed changes to marketing rules until 2025 to provide sufficient time for CMS to release – and plans to digest – the sub-regulatory guidance needed to successfully implement these new requirements.

- **Adoption of a Real-Time Prescription Benefit standard**: We urge CMS to specify in the Final Rule that adoption of the NCPDP Real-Time Prescription Benefit standard should not impede conformance to the industry standard of sending 4 drugs or 4 pharmacies for pricing in a single transaction.

- **Use of the Health Equity Index (HEI) Reward for Star Ratings:** We encourage CMS *not* to proceed with the HEI Reward for Star Ratings which would unfairly disadvantage contracts operating in States that are implementing DSNP-only contracts. We also encourage CMS to retain the current Star Ratings Reward Factor.

Additionally, in alignment with America's Health Insurance Plans and the Blue Cross Blue Shield Association, we urge CMS to delay the effective date of any finalized utilization management requirements to 2026. A 2026 effective date would provide plans time to fully assess changes to existing program requirements, reflect these changes in their bids, and modify contracts where necessary. Additionally, this timing would better align with the effective date for the proposed application programming interface requirements related to prior authorization in CMS's Advancing Interoperability and Improving Prior Authorization Proposed Rule.

Our detailed comments follow.

III. Enhancements to Medicare Advantage and Medicare Prescription Drug Benefit Programs

A. Health Equity in Medicare Advantage

Blue Shield supports the intent of the health equity proposals CMS describes at the beginning of the Proposed Rule, but we have concerns with the feasibility of CMS's proposals. On the new data elements for MA provider directories, we are concerned that compliance would be difficult for plans without additional federal or state requirements that create incentives for providers to submit timely and accurate information. If CMS wants to improve the content in provider directories, we encourage the agency to consider new policies aimed toward providers updating their data on a timely basis, and further support CMS pursuing a national provider directory from which plans could pull these data elements.

Blue Shield also has concerns about CMS's proposal to address digital literacy to support beneficiaries' use of telehealth services. It is unclear how plans would be expected to screen for and provide training to members for these needs. To scale this type of educational programming – particularly under a tight compliance deadline – it would have to be offered digitally, which likely is not the most effective mode of outreach for a population that faces challenges using telehealth, often including limited access to the Internet. We think this type of service would be more successful if delivered by community resources such as libraries that can provide in-person support.

Finally, regarding quality improvement activities to address health disparities, Blue Shield has been implementing quality improvement activities that address disparities in health and health care among enrollees for several years. For example, in 2022, we launched a bilingual inbound customer service team that provides in-language support without the use of a translator in 6 non-English languages. While we support the intent of this proposal, we do not feel it is necessary as plans have already widely adopted quality improvement activities that address health disparities.

O. Updating Translation Standards for Required Materials and Content

Blue Shield supports CMS's goal of providing accessible materials to member populations that are non-English language speakers or need auxiliary aids or services, but this proposal would be burdensome, expensive, and operationally challenging to implement, particularly by CY 2024. We expect the increased staff training that would be needed to comply with this proposal would jeopardize the availability and quality of customer service during the Annual Enrollment Period. Given the complexity of the proposal, we strongly encourage CMS to delay the proposed compliance deadline to CY 2025.

We also have concerns about the tight timeliness standards CMS proposes for translation services. We encourage CMS to amend its proposal and provide additional time or flexibility for plans to translate materials that include non-standardized language, such as correspondence for appeals and grievances and utilization management. These types of documents are difficult to translate and sufficient time should be provided to ensure accurate translation services.

P. Medicare Advantage and Part D Marketing

Blue Shield supports CMS's goals of protecting beneficiaries from misleading advertising and marketing practices. However, we are concerned that (1) these proposals would create barriers for beneficiaries getting the information they need to make informed decision about their coverage options; and (2) compliance with the multitude of new requirements that CMS has proposed would be extremely difficult to achieve for CY 2024. In addition to these concerns, we have the clarifying questions detailed below.

- CMS proposes several changes to marketing rules intended to separate educational events from marketing events. We request clarification from CMS on whether or not under these proposals an agent would be permitted to discuss a product or benefit that is different than what is specified by the Scope of Appointment and Business Reply Card if the beneficiary initiates the discussion to learn about a different product or benefit.

- CMS is proposing to prohibit MA organizations and Part D sponsors from marketing "savings" that are based on a comparison of typical expenses borne by uninsured individuals, unpaid costs of dual eligible beneficiaries, or other unrealized costs of a Medicare beneficiary. We request clarification or further guidance from CMS on whether or not marketing premium savings that a beneficiary may realize by switching from a commercial PPO plan at age 65 to a $0-premium MA plan would be allowed under this proposal.

In addition, CMS proposes prohibiting the use of the Medicare name, CMS logo, or official products, including the Medicare card, in a misleading manner. If this proposal is finalized, we would encourage CMS to provide additional guidance – with examples – on what it means to use the image of the Medicare card in a "misleading manner" in marketing materials.

R. Part D Medication Therapy Management (MTM) Program

Blue Shield appreciates CMS's interest in maximizing the benefits of the MTM Program and ensuring Medicare beneficiaries receive a Comprehensive Medication Review (CMR). However, we have significant concerns that the proposed expansion would overwhelm industry resources, significantly increase program costs, and ultimately create an impossible bar for plans to meet.

- Using CMS's estimate that 55 percent of beneficiaries would become eligible for the MTM Program under the proposed criteria, we estimate that Blue Shield's program membership would grow by approximately 400 percent. This would dramatically increase the costs of the MTM program, which are part of MA plans' bid costs, and result in a loss of rebate dollars that would otherwise be used to improve affordability or provide supplemental benefits that support members' well-being.

- Additionally, such a sudden increase in membership would be challenging to absorb given pharmacist shortages across the United States.[1] In recent years, pharmacists' scope of practice has expanded and responsibility for managing patients' care has grown while open positions have gone unfilled due to staff shortages.[2] We believe the dramatic expansion of MTM programs as proposed by CMS would exacerbate this workforce shortage and not be sustainable – there are simply not enough pharmacists in the United States to support MTM programs of the proposed size operating in all plans.

- Blue Shield also has concern that expanding the MTM Program would create duplication with other programs and services that beneficiaries with chronic conditions already access, like case management and annual wellness visits. Overlap between these services and the MTM Program not only would create redundant care management efforts but could result in beneficiary confusion.

- Finally, we oppose the addition of cancer and HIV/AIDS to the MTM Program's core condition list. Beneficiaries with these conditions receive specialty care and use specialty pharmacies, which provide regular CMRs and extensive counseling regarding their medication regimen.

To mitigate these concerns, we urge CMS not to move forward with its proposed changes. However, if CMS chooses to finalize this proposal, we strongly encourage the agency to phase in the eligibility expansion over time and incorporate the following changes to its proposals:

- Rather than requiring Part D sponsors to include *all* Part D maintenance drugs, adjust the maximum number of maintenance drugs from 8 to 6.

- Provide more year-to-year consistency in the cost criteria. For example, we recommend CMS set the cost criteria at $4,000 and reassess that amount based on average drug prices after at least 2 consecutive years with the same cost criteria.

Additionally, we encourage CMS to consider other strategies for growing the pharmacist workforce, expanding the reach of the existing pharmacist workforce by recognizing pharmacists as providers, and providing pharmacists incentives to access to richer data on patient medical histories, such as through health information exchanges.

S. Standards for Electronic Prescribing

Blue Shield supports CMS's proposal to require Part D sponsors to adopt the National Council for Prescription Drug Plans' (NCPDP) Real-Time Prescription Benefit (RTPB) transaction standard. However, the current NCPDP RTPB standard version 12 only supports transactions with one drug or pharmacy at a time while the current industry norm allows electronic health

[1] Tyko, Kelly, "Walmart and CVS cutting pharmacy hours," Axios, Last modified January 27, 2023, https://www.axios.com/2023/01/27/cvs-pharmacy-hours-walmart-hours-shortage.
[2] "Survey: Three Quarters of Community Pharmacies Report Staff Shortages," National Community Pharmacists Association, Published on August 11, 2022, https://ncpa.org/newsroom/news-releases/2022/08/11/survey-three-quarters-community-pharmacies-report-staff-shortages.

record (EHR) systems and payer digital technologies to send up to 4 drugs or 4 pharmacies for pricing in a single transaction.

Given that discrepancy, we urge CMS to further specify that the adopted standard is consistent with the current industry norm that, as noted above, allows EHR systems and payer digital technologies to send up to 4 drugs or 4 pharmacies for pricing in a single transaction. This capability ensures beneficiaries and prescribers have visibility into the most cost-effective drugs and pharmacy alternatives by not exceeding the transaction latency standard of 3 seconds of less for 99 percent of transactions in EHR, web, and mobile platforms. It is critical that the adopted transaction standard supports the current industry norm because:

- Identifying and pricing lower-cost formulary alternatives requires allowing multiple drugs in a single RTPB transaction. Failure to require at least 4 drugs in a single RTPB transaction would necessitate multiple, consecutive transactions to price all appropriate alternatives, which creates more time latency in returning pricing responses for display to beneficiaries and prescribers.

- The primary purpose of RTPB, as noted by CMS, is to identify and support the most cost-effective medication for prescribing. This requires identifying, pricing, and delivering to prescribers lower-cost, therapeutic-equivalent alternatives **at the point of prescribing in 3 seconds or less.** The current NCPDP RTPB standard only supports transactions with one drug or pharmacy at a time. When submitted in sequence to price alternatives rather than allowing 4 in a single transaction, the latency is expected to exceed 3 seconds, surpassing standards for EHRs and resulting in error or reject messages.

- According to the Congressional Budget Office, Medicare enrollees have increased their use of prescriptions to treat co-morbidities to an average of 54 prescriptions per year in 2018, resulting in an increase in enrollee out-of-pocket cost burden.[3] Enrollees benefit from an expanded view of potential cost savings and should not be limited to one prescription at a time to find savings.

- Currently, the vast majority of RTPB transaction responses sent to prescribers only provide pricing for one selected drug and does not include lower cost alternatives.[4] Failure to require up to 4 drugs in a single RTPB transaction will functionally guarantee that lower cost formulary alternatives will not be delivered, undermining CMS's prior rulemaking on RTPB tools (CMS-4180-F and CMS-4190-F).

Again, we encourage CMS to ensure that the adopted standard enables EHR systems and payer digital technologies to send up to 4 drugs or 4 pharmacies for pricing in a single transaction. It is critical that beneficiaries, prescribers, and pharmacists are able to see the intended information delivered through their preferred point-of-care platform.

[3] Tamara Hayford et al. "Prescription Drugs: Spending, Use, and Prices," Congressional Budget Office, Published January 19, 2022, https://www.cbo.gov/publication/57050.
[4] *JAMA Intern Med*. 2022;182(11):1129-1137. doi:10.1001/jamainternmed.2022.3946 Published online September 12, 2022.

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System

C. Contract Ratings

We agree with CMS's methodology and proposed clarification for calculating Star Ratings for the Parts C and D improvement measures for the first and second years after contracts consolidate. We believe CMS's process for calculating the improvement measures after a contract consolidation is fair and preserves accuracy by *not* calculating measure-level scores the first year of a consolidated contract.

D. Adding, Updating, and Removing Measures

a. Diabetes Care—Kidney Disease Monitoring (Part C)

Blue Shield of California supports the removal of the Diabetes Care—Kidney Disease Monitoring measure beginning with the 2024 Star Ratings. We had planned for this change in accordance with prior CMS guidance. We recommend that Kidney Health Evaluation for Patients with Diabetes measure be added to the 2024 Star Ratings to ensure that a similar kidney disease measure is monitored in the Star Ratings program.

b. Medication Reconciliation Post-Discharge (Part C)

We request clarification from CMS on the timing of the proposed removal of the Medication Reconciliation Post-Discharge (MRP) measure. It was our understanding from prior CMS guidance that this measure would be retired with 2022 Star Ratings, as the measure would become a component of the Transitions of Care measure effective with 2022 Star Ratings. As CMS indicates in the CY 2024 Advance Notice, keeping MRP as a stand-alone measure alongside the Transitions of Care measure would be duplicative and effectively weight MRP at 1.25 instead of 1 (the standard weight for process measures).

We request that CMS retire the stand-alone MRC measure in 2022 Star Ratings (as Transitions of Care enters the program) or delay the introduction of the Transitions of Care measure until 2024 Star Ratings to coincide with the proposed retirement of the stand-alone MRC measure.

a. Colorectal Cancer Screening (Part C)—Substantive Change

We support CMS's proposal to expand the eligible age range for the Part C Colorectal Cancer Screening measure in alignment with current USPSTF guidance and changes made by the measure steward, NCQA.

b. Care for Older Adults—Functional Status Assessment (Part C) Substantive Change

Blue Shield appreciates CMS's interest in ensuring functional status assessments are conducted to understand and address beneficiaries' activities of daily living (ADLs) and instrumental activities of daily living (IADLs). However, we do not support the return of the Care for Older Adults—Functional Status Assessment (COA—FSA) measure.

The underlying activities captured in COA-FSA are already monitored through existing measures in the Star Ratings program, such as the Special Needs Plan (SNP)—Care Management measure as well as the new Physical Functioning Activities of Daily Living (PFADL) measure.

Specifically, ADLs and IADLs are assessed through standard Health Risk Assessments (HRAs) and HRA completion rates are a component of the SNP-Care Management measure, which applies to the same population as the COA-FSA measure. Moreover, if CMS moves the PFADL measure off the display page and into the Health Outcomes Survey (HOS) measure set, plans would likely complete functional status assessments and address identified needs in screening tools.

c. Medication Adherence for Diabetes Medication, Medication Adherence for Hypertension (RAS Antagonists), Medication Adherence for Cholesterol (Statins) (Part D)—Substantive Change

Blue Shield does not support CMS's proposed changes to the Part D medication adherence measures. First, we oppose applying risk adjustment based on sociodemographic status to the 3 Part D medication adherence measures. Applying risk adjustment at the measure level would make tracking individual measure performance much more complicated for plans and run counter to CMS's expressed interest in simplifying Star Ratings. We strongly encourage CMS to continue adjusting these measures through the Categorical Adjustment Index. Alternatively, if CMS wants to pursue case-mix adjustment for medication adherence measures, we urge the agency to adopt the Pharmacy Quality Alliance's combined medication adherence measure -- Proportion of Days Covered -- and consider applying a case-mix adjustment to that measure.

Blue Shield also opposes CMS's proposal to exclude Inpatient and Skilled Nursing Facility (SNF) days from the calculation of covered days for these medication adherence measures. We are concerned that the proposal to apply a sociodemographic status risk adjustment would not adequately offset the exclusion of Inpatient and SNF days, especially as many of these types of stays are unrelated to social risk factors. For example, a debilitating injury that requires a long stay is not limited to individuals with social risk factors.

In addition, we find that members who experience an Inpatient stay often have extra medication supplies at home as their medications were administered by facility pharmacies during the Inpatient stay. Those unused medical supplies add up the longer and more frequently a member is admitted to the hospital. We also see this with members who are admitted to Long-Term Care facilities. Based on this experience, we recommend that CMS add Long-Term Care days to the list of exclusions.

Ultimately, we do not find the Inpatient and SNF exclusions to be complex or burdensome, and therefore do not believe that eliminating them from the medication adherence measures would simplify the Star Ratings program in a meaningful way.

Finally, we request clarification from CMS on the use of continuous enrollment for the medication adherence measures. Specifically, we request clarification on whether a member

with a gap in enrollment would be excluded for the *entire* measurement period or if their first period of enrollment would be maintained in the measure.

b. Concurrent Use of Opioids and Benzodiazepines (COB), Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH) and Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults (Poly-CNS) (Part D)

Blue Shield does not support the addition of the Concurrent Use of Opioids and Benzodiazepines or either of the Polypharmacy measures to Star Ratings. These medications are already tightly controlled through formulary, benefit, utilization management, and clinical monitoring. Additional monitoring through Star Ratings would be redundant and may restrict access to medically necessary drug regimens, putting patients at risk for clinical decompensation.

If changes to a patient's medication regime – particularly an opioid medication – need to be made, dosage tapering and management of withdrawal symptoms is required. These clinical practices and patient safety efforts are not accounted for in the measure specifications. In addition, some members are stabilized on multiple anticholinergic medications. We are concerned that the addition of these related Star measures could result in abrupt changes to patients' medication regime and put patients at risk of clinical decompensation or other harm.

Finally, given the substantial overlap between the Concurrent Use of Opioids and Benzodiazepine and the Polypharmacy—Central Nervous System measure, we believe use of both measures would be redundant. We request that CMS *not* require both measures.

4. Revising the Rule for Non-Substantive Measure Updates

We support CMS's proposal to simplify the process for making non-substantive measure updates. However, we encourage CMS to continue to communicate these updates with plans through rulemaking like the Advance Notice or the Policy and Technical Changes Proposed Rule.

5. Measure Removal

We support CMS simplifying the process to remove measures alongside measure stewards. However, we encourage CMS to continue to communicate these updates with plans through rulemaking like the Advance Notice or the Policy and Technical Changes Proposed Rule.

E. Measure Weights

1. Patient Experience/Complaints and Access Measures

Blue Shield agrees with CMS's assessment that weighting the Patient Experience/Complaints and Access measures at 4 has created an imbalance in the contribution of different types of measures to plans' Star Rating score. We support CMS's proposal to bring the weight of these measures back down to 2, and strongly encourage CMS to make this change sooner than the

2026 Star Ratings. We think it is a priority to correct the current weighting imbalance as soon as possible.

2. Weight of Measures with Substantive Updates

We support CMS's proposal to codify its current practice of assigning a weight of 1 the first year that measures with substantive updates are added back to the Star Ratings program. Following that first year, as CMS notes, the measure would be assigned the weight associated with its category. We believe this process provides plans sufficient notice to familiarize themselves with a measure's updated specifications, assess potential impacts, and incorporate changes to internal processes if needed.

F. Guardrails

Blue Shield urges CMS to continue to use existing cutpoint guardrails. We believe that the Tukey outlier deletion and mean resampling will help stabilize cutpoints, but we believe the guardrails continue to be an important factor in improving the stability and predictability of cutpoints. We recommend CMS observe the true impact of the Tukey outlier deletion and mean resampling alongside guardrails for several years and then reevaluate the need for the guardrails policy.

G. Health Equity Index Reward

Blue Shield recognizes the importance of health equity and is working toward more equitable health outcomes for our members. We found CMS's Health Equity Summary Score Dashboard, which included stratified, measure-level performance reports, to be helpful in our efforts to identify performance improvements and health disparities. However, we have several significant concerns with CMS's proposal to replace the Reward Factor with a Health Equity Index (HEI) Reward and urge CMS to not finalize this proposal.

Our primary concern stems from the flexibility CMS granted to states in the CY 2023 Medicare Advantage and Part D Policy and Technical Changes Final Rule to require MA organizations to establish one or more DSNP-only contracts. The State of California chose to adopt this flexibility beginning in CY 2024. As such, MA organizations in California will have to apply for a new contract and then crosswalk their DSNP membership to that new contract. This will leave MA organizations' legacy contracts with very few SNP members, which typically account for the majority of a contract's Low-Income Subsidy (LIS), Dual Eligible (DE), and disabled members.

Under the proposed Health Equity Index Reward methodology, it is unlikely that non-DSNP contracts in states like California would be eligible for an HEI adjustment because the percentage of enrollees with social risk factors (SRFs) would be too small to make that contract eligible for an HEI adjustment. Under CMS's proposal, these contracts would not only be unlikely to receive an HEI adjustment but would be further disadvantaged by the proposed removal of the current Reward Factor. This proposal would unfairly disadvantage contracts operating in States that are implementing DSNP-only contracts. In addition to the DSNP-only contract issue, we are

concerned that the eligibility requirements CMS is proposing would make it difficult for plans to receive an HEI adjustment as percentage of members with SRFs falls under the national median for the majority of contracts.

We recommend CMS consider a compromise in which the current Reward Factor and proposed Health Equity Index Reward could operate together: keep but limit the Reward Factor to a maximum reward of 0.2 Stars *and* introduce a Health Equity Index Reward capped at a maximum reward of 0.2 Stars.

H. Improvement Measure Hold Harmless

Blue Shield agrees that plans should always be driving toward continued quality improvement, but we strongly disagree with CMS's proposal to limit the hold harmless rule for improvement measures to plans with a 5-Star rating. We disagree with the rationale that applying the hold harmless to 4-Star and 4.5-Star measures discourages plans from striving for additional improvement. Blue Shield's H0504 contract has been a 4-Star plan for several years. We still set each measure's target rating to not only achieve the 4 or 5-Star cutpoint, but to account for continuous improvement if our prior performance was higher than our projected cutpoint.

We find that the retrospective clustering methodology and mean resampling are natural motivators of continuous improvement. At the same time, we have seen 4- and 5-Star cutpoints become increasingly challenging for many measures. For some measures, the cutpoints are only separated by one or two percentage points. When a plan is operating at mostly the 4- and 5-Star levels, it is extremely difficult to continue to meet the cutpoints and to continuously improve; the margin for improvement is simply much more narrow at the highest Star levels. We believe that the hold harmless rule was sensibly and fairly applied to plans with 4-Stars and above for this reason, and believe these issues continue to exist and necessitate the application of the hold harmless rule.

I. Extreme and Uncontrollable Circumstances

We support CMS's proposed changes to the Extreme and Uncontrollable Circumstances (EUC) policy. We saw how important waiving the 60 percent rule was when the EUC policy was triggered by the COVID-19 Public Health Emergency. We also believe that the Tukey outlier deletion would resolve the issue of outlier plan performance due to an extreme and uncontrollable circumstance. We also support CMS codifying the process for adjusting the HOS measures.

J. Quality Bonus Payment Rules

We support CMS's proposals regarding the Quality Bonus Payment refute process. In our experience, the First and Second Plan Preview processes provide sufficient opportunities to refute suspected errors. We believe, after the Second Plan Preview process, a Quality Bonus Payment refute should only occur in the case of a clerical or similar error that may have occurred between the Plan Preview and the Quality Bonus Payment validation process.

K. Calculation of Star Ratings

While we expected codification of the Tukey outlier deletion methodology for the 2024 Star Ratings, we encourage CMS to delay implementation to give plans more time with the simulation documents they received in December 2022 to understand the methodology and assess impact.

Stars Questions Not Addressed in the CY 2024 Policy and Technical Proposed Rule

Blue Shield requests clarification from CMS on the status of the measures described below. These are measures that CMS proposed taking action on in previous rulemakings but – to our knowledge – has not yet addressed.

Annual Flu Vaccine

CMS proposed moving the Annual Flu Vaccine measure out of the CAHPS survey and into the HEDIS measure set. We agree with this proposal. The administration of a vaccine can easily be captured in claims, PDE, and/or medical records, making it well suited to be a HEDIS measure along with other clinical measures. We think this will be a more reliable approach to collecting information about administration of the flu vaccine than asking a member to recall whether or not they received the vaccine. We request CMS confirm whether or not this proposed change to the Annual Flu Vaccine measure will be implemented in the 2025 Star Ratings (Measurement Year 2023).

Beneficiary Action & Performance Problems

CMS previously proposed adding Beneficiary Action & Performance Problems to the Star Ratings program. We support the addition of this measure to the program, although have concerns about how the measure may discourage plans from self-reporting access and performance problems. We request CMS confirm whether or not this measure will be added to the 2025 Star Ratings (Measurement Year 2023).

Complaints About the Health Plan

CMS had proposed adding "marketing misrepresentations" into the Complaints about the Health Plan measure. We request confirmation from CMS on whether or not this proposed modification will occur in the 2025 Star Ratings (Measurement Year 2023).

Care for Older Adults

CMS previously proposed adding digital indicators for the Care for Older Adults measures and transitioning these measures to electronic clinical data systems (ECDS) reporting methods. We request CMS confirm whether or not this change to reporting the Care for Older Adults measure is effective for the 2025 Star Ratings (Measurement Year 2023).

HEDIS Frailty Exclusions

CMS proposed requiring more than one code for HEDIS frailty exclusions. We request confirmation from CMS on whether or not this change to the HEDIS frailty exclusions would be effective for the 2025 Star Ratings (Measurement Year 2023).

Conclusion

Thank you again for the opportunity to provide comments on these proposed changes. We welcome the opportunity to respond to any follow-up questions you have.

Sincerely,

Andy Chasin
Vice President, Federal Policy and Advocacy
Blue Shield of California

TAB 20

As of: March 04, 2024
Received: February 13, 2023
Status: Posted
Posted: February 17, 2023
Category: Health Plan or Association
Tracking No. le3-ea84-9xcc
Comments Due: February 13, 2023
Submission Type: API

PUBLIC SUBMISSION

Docket: CMS-2022-0191
Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024

Comment On: CMS-2022-0191-0001
Medicare Program: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, etc.

Document: CMS-2022-0191-0826
Comment on CMS-2022-0191-0001

Submitter Information

Email: james.michel@cigna.com
Organization: The Cigna Group

General Comment

Please see attached.

Attachments

Cigna CY 2024 MA Part D Proposed Rule Comments - 20230213 Final

Kristin Julason Damato
Senior Vice President
Global Public Policy & Government Affairs
Cigna Group
701 Pennsylvania Avenue, NW
Suite 720
Washington, DC 20004
Telephone (202) 719-5557
Facsimile (202) 719-6755
Kristin.JulasonDamato@TheCignaGroup.com

February 13, 2023

VIA ELECTRONIC SUBMISSION TO www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Contract Year (CY) 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

To Whom It May Concern:

Cigna welcomes the opportunity to respond to the *CY 2024 Policy and Technical Changes to the Medicare Advantage Program and Medicare Prescription Drug Benefit Program* proposed rule. Cigna provides commentary, feedback, and recommendations on many of the proposals contained in this proposed rule; taken together, the numerous proposals in this rule across several critical areas of the Medicare Advantage (MA) and Part D programs represent significant change over a short period of time. We urge CMS to consider overlapping impacts, operational complexity, and potential disruption that may result when implementing portions of this rule, especially in light of other large-scale changes taking place outside of its scope.

The Cigna Group is a global health company committed to improving health and vitality. Our subsidiaries are major providers of medical, pharmacy, dental, and related products and services, with over 190 million customer relationships in the more than 30 countries and jurisdictions in which we operate. Within the United States, Cigna provides medical coverage to approximately 14 million Americans in the commercial group health plan market, predominantly in the self-insured segment. We also provide coverage in the individual Affordable Care Act insurance segment in several states, both on- and off-Exchange, to about 235,000 people. Additionally, we serve more than 4.5 million people through our MA, Medicare Prescription Drug Program and Medicare Supplemental products. In all of the segments we serve, Cigna is focused on creating products and services that support a quality, affordable, equitable, and sustainable health care system for all Americans.

This proposed rule would implement extensive changes to the rules and regulations governing some of the most fundamental programs underpinning the MA and Part D programs. We thank CMS for its thoughtful approach in proposing changes that seek to strengthen and sustain these programs for Medicare beneficiaries today and into the future, but we are concerned some of them would have the opposite effect. In this letter, we offer feedback and recommendations on many of these proposals, with particular emphasis on the proposals we believe pose the most risk of undermining the program and the value it

provides to beneficiaries today. While our detailed comments are in the Appendix, below is a summary of our key issues, concerns, and recommendations for CMS' consideration:

Utilization Management and Prior Authorization

Prior authorization and other utilization management tools are critical tools to help protect beneficiaries' health and safety while improving affordability and reducing unnecessary costs. They ensure Medicare benefits are delivered when appropriate and medically necessary, as required by law. The proposed rule would significantly limit MA plans' ability to exercise prior authorization and care coordination, and we have serious concerns about the consequences of these changes for beneficiaries and taxpayers. Moreover, we note the overlapping impacts of this proposed rule with other regulatory proposals related to interoperability, prior authorization, and claims attachments; and we request CMS better align these multiple efforts. Given these considerations, Cigna recommends:

- CMS should not prohibit MA plans from using prior authorization as a tool to determine *when, where,* and *how* Medicare benefits and services are best provided to individuals based on clinical need;
- CMS should maintain the integrity and utility of manuals and instructions, as well as the ability of MA plans to use the evidence-based clinical guidelines widely used today; and
- CMS should align the implementation of any prior authorization policy changes to the timelines of other significant proposed rules regarding interoperability and claims attachments.

Marketing and Education

Effective marketing and education is the most effective way to ensure beneficiaries have the most accurate and reliable information needed to make an informed decision about their coverage options. In this rule, CMS is proposing additional rules and guidelines to improve the quality of information beneficiaries receive and reduce the likelihood of beneficiaries enrolling in the wrong plan based on bad information or misunderstanding. While we support many of the proposals in this section, we ask CMS to consider the timing, ask for additional clarity, and raise concerns that some proposals may actually create barriers to getting the right information to beneficiaries that is necessary for them to make informed coverage decisions. Specifically Cigna recommends:

- CMS delay any implementation of significant changes to marketing rules and regulations until at least the 2025 plan year, to give stakeholders enough time to implement changes in advance of the Annual Election Period (AEP);
- CMS provide additional clarity, including specific examples, of what language, statements, images, and other representations would be permissible under the proposed changes around advertising content, including the use of cost comparisons;
- CMS not finalize proposals to separate marketing and educational events due to concerns that such will create unnecessary burdens to some beneficiaries, especially those with transportation challenges and those who live in rural areas; and
- CMS consider proposals that would reinforce a beneficiary's right to opt out of communications rather than place arbitrary limits on the collection of contact information and timeframes for allowable outreach.

Quality and Star Ratings

The MA and Part D Star Ratings System has been one of the most successful tools to incentivize quality improvement activities and ensuring beneficiary satisfaction and access to care. MA and Part D plans have seen significant improvements across a range of quality

measures and domains, resulting in better care and outcomes for patients. While we offer detailed comments to some of the more technical proposals, we offer the following recommendations on the more significant methodological Stars proposals:

- We strongly urge CMS to finalize its proposal to reduce the weight of patient experience/access measures from 4 to 2;
- CMS finalize its proposal to replace the current Reward Factor with a health equity index (HEI) adjustment beginning with 2027 Star Ratings;
- CMS not finalize its proposal to eliminate the 5% guardrails that were recently implemented to limit measure cut-point movement each year, considering other methodological changes (e.g., Tukey outlier method) already finalized to take effect; and
- CMS not finalize its proposal to limit the improvement hold-harmless provisions to 5-Star plans and should maintain the current policy of application to any contract with a summary rating of 4 Stars or higher.

With these priority recommendations as context, and with our more detailed comments contained in the Appendix, we thank CMS for its consideration of these comments. We look forward to engaging on these proposals, and would welcome the opportunity to discuss these issues with you in more detail at your convenience.

Respectfully,

Kristin Julason Damato

* * *

Appendix: Cigna Detailed Comments

Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Programs (Section II)

A. Health Equity in Medicare Advantage (MA) (§§ 422.111, 422.112, and 422.152)

Current regulations require MA organizations to ensure that services are provided in a culturally competent manner and the regulation provides examples of populations that may require consideration specific to their needs. CMS is proposing to amend the list of populations to include people:

- With limited English proficiency or reading skills;
- Of ethnic, cultural, racial, or religious minorities;
- With disabilities;
- Who identify as lesbian, gay, bisexual, or other diverse sexual orientations;
- Who identify as transgender, nonbinary, and other diverse gender identities;
- Who are born intersex;
- Who live in rural areas and other areas with high levels of deprivation; and
- Otherwise adversely affected by persistent poverty or inequality.

Furthermore, CMS provides best practices for organizations to use in developing their provider directories, including incorporating non-English languages spoken by each provider and provider/location accessibility for people with physical disabilities. In this rule, CMS is proposing to require organizations to include providers' cultural and linguistic capabilities (including American Sign Language) in their provider directories.

To address disparities in telehealth access due in part to low digital health literacy, CMS is also proposing to require MA organizations to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy assistance with accessing any medically necessary covered telehealth benefits.

Finally, CMS is proposing to require MA organizations to incorporate one or more activities that reduce disparities in health and health care among enrollees into overall quality improvement (QI) programs. The agency notes MA organizations' existing QI programs are an optimal vehicle to develop and implement strategies and policies designed to reduce disparities in health and health care, and advance equity in the health and health care of MA enrollee populations, especially those that are underserved.

Cigna Comments:

Cigna supports CMS' goals to advance health equity. We believe health starts in the communities where we live, work, learn, and play. For nearly 15 years, Cigna has promoted the identification of health disparities and influenced the development of solutions that result in improved health outcomes. We do this by leveraging an array of data sources and tools like our proprietary Social Determinants Index (SDI) that allows us to analyze customer populations to understand their potential health disadvantages and build innovative solutions to enhance our clinical program offerings, close disparity gaps, and better serve our customers, our network providers, and the greater community. Through Cigna's enterprise-wide Health Equity Committee we seek to ensure that all people can achieve their full health potential regardless of socioeconomic or environmental circumstances.

We offer the following comments, clarifying questions, and recommendations in response to CMS' proposals relating to health equity:

- **Adding new populations to cultural competency requirements:** Cigna is encouraged by CMS's commitment to addressing the needs of the populations enumerated, but we strongly recommend a phased approach to enable plans to implement form and program changes that best meet the needs of our beneficiaries. Expanding the requirements to this many new population groups will require significant changes to enrollment forms, health risk assessments (HRAs), and an overhaul of multiple workflows. A phased implementation will help to minimize disruption and confusion to beneficiaries.

- **Requiring searchable provider directories:** While Cigna supports overarching efforts to improve the accuracy and utility of provider directories, we recommend that proposed requirements for new directory data elements be aligned with longer-term solutions involving a national directory of healthcare providers and services (NDH). Development of a larger NDH would achieve improved efficiencies for all stakeholders across the health care system. Notwithstanding, if CMS pursues near-term implementation of the new MA directory data elements, we strongly recommend: (1) CMS provide enforcement discretion to allow for proper development, testing, implementation, and refinement of data collection methods within a very short timeframe; and (2) CMS require provider organizations to manage the collection of this information for their individual clinicians and attest to its accuracy.

- **Requiring plans to provide digital health education:** Cigna supports digital health education and appreciates the flexible approach in CMS' proposed changes. Cigna currently supports members through partnerships with organizations such as Findhelp, which can connect members with federal resources and community organizations for free/reduced cost Wi-Fi and other methods of internet connection. These members are identified during interactions with clinical staff. Cigna agrees that further efforts to support digital health education will be important as telehealth grows in use for the Medicare population. Given this is a rapidly evolving area, we also appreciate the proposal's flexibility to give plans the discretion to design a screening tool and develop educational materials for members. This flexibility will allow us to continue to innovate in digital health solutions for beneficiaries.

- **Incorporating one or more health equity-focused activities in QI programs:** Cigna is actively involved in efforts to address social determinants of health (SDOH) to reduce health care disparities among MA enrollees as part of our QI programs. Cigna MA employs bilingual staff and administers social work programs that connect members to a wide range of Cigna benefits. Cigna supports efforts to encourage more health equity-focused quality initiatives, and we appreciate the flexibility embedded within this proposal which will allow plans to tailor initiatives that are best suited for their unique populations.

B. Behavioral Health in Medicare Advantage (MA) (§§ 422.112, 422.113, and 422.116)

CMS proposes the five following changes to strengthen its network adequacy requirements and reaffirm MA organizations' responsibilities to provide behavioral health services:

- Add Clinical Psychology, Licensed Clinical Social Workers, and Prescribers of Medication for Opioid Use Disorder (OUD) as specialty types that will be evaluated as part of the network adequacy reviews, and make these new specialty types eligible

for the 10-percentage point telehealth credit. Currently, MA organizations are only required to demonstrate they meet network adequacy for two behavioral health specialty types: psychiatry and inpatient psychiatric facility services.

- Amend general access to services standards to explicitly include behavioral health services. Specifically, CMS proposes to add behavioral health services to the types of services for which MA organizations must have programs in place to ensure continuity of care and integration of services.

- Codify standards for wait times that apply to both primary care and behavioral health services. CMS is proposing these changes to increase and enhance access to equitable behavioral health care services, similar to how beneficiaries access needed physical health services.

- Clarify that behavioral health services may qualify as emergency services and, therefore, must not be subject to prior authorization. CMS is proposing this change to ensure that emergency medical conditions are easily interpreted as including mental health and thereby guarantee coverage is provided by the MA organization at parity with access to other medical emergency services.

- Extend current requirements for MA organizations to establish programs to coordinate covered services with community and social services to behavioral health services programs to close equity gaps in treatment between physical and behavioral health.

Cigna Comments:

Cigna is committed to ensuring beneficiaries have access to an array of behavioral health professionals and services in the face of a nationwide behavioral health provider shortage. We support CMS' efforts to expand the behavioral health workforce through expanded education programs and other investments to spur growth in the number of providers.

The COVID-19 pandemic accelerated a tectonic shift to virtually-enabled care across the health care spectrum, but especially in behavioral health. In recognition of this, Cigna and Evernorth worked quickly to add virtual care resources to its behavioral health network, and experienced a 60% increase in behavioral health patients using virtual services compared to pre-pandemic levels. We continue to innovate through greater integration of physical and behavioral health care; leveraging virtual solutions, such as MDLIVE, to expand access to those who live in areas with little or no physical behavioral health access.

Cigna appreciates CMS' ongoing commitment to incentivize greater access to behavioral health providers. We firmly believe the root cause of provider supply must continue to be addressed. The root cause of provider supply is far beyond MA plans' control, and we urge CMS to recognize this fact when establishing network and access standards.

With regard to adding new behavioral health provider types to MA network adequacy standards, and to extending requirements to establish behavioral health coordination programs with community-based social services, **Cigna strongly urges CMS to delay these requirements to plan year 2025.** Given the timing of this proposed rule, and the publication of the subsequent final rule and associated guidance, we are concerned plans will not have sufficient time to engage in the level of provider contracting needed to satisfy these requirements for 2024, especially when considering recent CMS rule changes to push back the time when networks must be complete for the following plan year. Additionally, **Cigna requests CMS allow a flexible exceptions process, for at least the first few**

years of these new requirements, to account for systemic provider shortages and other root cause issues beyond plans' control.

Cigna also strongly supports CMS' proposal to allow the 10-percentage point telehealth credit for the new behavioral health specialty types. We urge CMS to allow maximum flexibility to provide virtual BH solutions that would satisfy new network and access standards. Additionally, **we urge CMS not to adopt strict appointment wait time requirements and continue to allow flexibility in meeting existing standards consistent with sub-regulatory guidance.** The above recommendations will provide that we build on and sustain the fostering of innovative solutions for providing and accessing behavioral health and substance use disorder treatment as we work to champion optimal treatment and support in this area.

C. *Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (§§ 422.101, 422.112, 422.137, and 422.138) (Section II.E.)*

Utilization management tools are critical to ensuring that beneficiaries receive care that is clinically appropriate and consistent with evidence-based medicine principles. Cigna agrees with CMS' view that prior authorization, and utilization management tools more broadly, are important means to help coordinate care, reduce inappropriate utilization, and promote cost-efficient care (87 Fed. Reg. at 79498). For this reason, we have grave concerns that some of the changes CMS proposes in this rule will result in the unintended consequence of fundamentally undermining MA plans' ability to exercise these critical functions. We also agree with CMS that process and operational improvements are needed, and we note the additional efforts across CMS and HHS to implement reforms will ultimately lead to these improvements. **We strongly recommend CMS align the timelines of various efforts and regulatory activities impacting prior authorization, including those contained in the Interoperability and Prior Authorization proposed rule. Specifically, we ask CMS not to implement any significant changes to prior authorization and UM tools before 2026 and to align the implementation timeline with the interoperability proposed rule.**

Cigna offers additional comments on the various proposals in this section driven by a fundamental guiding principle that MA plans should maintain their ability to use UM tools effectively for the benefit of beneficiaries and the health care system.

1. *Coverage Criteria for Basic Benefits (including Medical Necessity Determinations) (Section II.E.2. and II.E.3.)*

CMS proposes to codify standards for coverage criteria to ensure that basic benefits coverage in MA is no more restrictive than traditional Medicare so that benefits are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." In addition, CMS proposes to clarify that MA organizations must comply with general coverage and benefit conditions included in traditional Medicare national coverage determinations (NCDs), local coverage determinations (LCDs), and laws, unless there are specific laws applicable to MA.

When coverage criteria are not fully established in Medicare statute, regulation NCD, or LCD, an MA plan would be able to create internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature that is publicly available. When making the internal criteria, MA plans would be required to describe a summary and list of the sources of evidence that was considered and an explanation of the rationale.

CMS proposes changes to medical necessity determination requirements, including:

- Requiring that MA organizations consider whether the item or service is reasonable and necessary under Medicare's definition of reasonable and necessary at section 1862(a)(1);
- Codifying that MA organizations must consider the enrollee's medical history, physician recommendations, and clinical notes; and
- Requiring that MA organizations' medical directors be involved in ensuring the clinical accuracy of medical necessity decisions where appropriate. CMS seeks feedback on when this would be appropriate.

CMS also describes in the preamble language that MA plans would be restricted in their ability to limit "when and how" they cover basic Medicare benefits, so that if care can be delivered in more than one way and a provider has ordered or requested items or services for an enrollee, the MA organization may only deny coverage on the basis of the ordered services failing to meet criteria outlined in Medicare coverage rules. If an enrollee in an MA plan is discharged with a physician order for post-acute care, the MA organization would not be able to deny coverage for care in the ordered PAC setting and redirect care toward a different setting.

To clarify appropriate use of prior authorization, CMS proposes to clarify that a coordinated care plan may use prior authorization processes for basic benefits and supplemental benefits only to confirm the presence of diagnoses or other medical criteria that are the basis for coverage determinations to ensure that benefits are medically necessary for basic benefits or clinically appropriate for supplemental benefits.

Cigna Comments:

CMS proposes to remove the reference to "original Medicare manuals and instructions," and clarify that MA organizations must comply with "general coverage and benefit conditions include in Traditional Medicare laws" when making coverage decisions, which include Medicare statute, regulation, and both NCDs and LCDs. CMS explains that by removing this reference, they are not diminishing the content and value provided by manuals and instructions and they should be relied upon to interpret and define the scope of Part A and B benefits. **Cigna agrees manuals and instructions are an important resource, and we urge CMS to maintain the integrity and utility of the information contained in these manuals to the extent they provide coverage guidance where Medicare is otherwise silent.** Specifically, CMS should modify its regulatory text to state that Medicare manuals and other CMS-issued guidance may be adopted by MA plans as internal coverage criteria that encapsulate "widely used treatment guidelines," without the requirement to provide summaries of evidence and rationales for the adoption of these CMS manuals and guidance documents.

Cigna supports CMS's efforts to ensure that Medicare beneficiaries receive care that is consistent with the statutory, regulatory specifications for coverage of basic benefits, as well as existing NCDs and LCDs. Cigna MA has long adhered to these requirements and determinations. Moreover, Cigna MA has viewed Medicare manuals and other CMS-issued guidance as key to applying requirements and determinations. Although CMS manuals and guidance do not rise to the level of statute and regulation, these issuances have been used to shape coverage criteria and medical necessity determinations. Because CMS manuals and guidance are government-issued, publicly available information that have gone through government processes, such materials should not be subject to the same type of required explanations. MA organizations should be permitted to cite these CMS issuances as internal coverage criteria that are based on widely used treatment guidelines and clinical literature.

Additionally, CMS should allow MA plans flexibility involving how MA plans' UM tools are applied to the circumstances of when, where and how items and services are delivered to beneficiaries. MA organizations can and should be required to comply with and implement specific statutory, regulatory and NCD/LCD coverage criteria and requirements that specify where, when and how items and services are delivered. However, in the absence of such specified requirements, MA organizations should have flexibility to ensure that beneficiaries receive Medicare-covered benefits in the most clinically appropriate and cost-effective way for that individual, using evidence-based guidelines and approaches. We disagree with the implication that providing the same Medicare-covered service in a different way, in an alternative setting, or with a different clinically appropriate clinician is somehow considered non-coverage of that benefit. **We urge CMS to draw a clearer distinction between Medicare *benefit* policy and Medicare *payment* policy.** MA organizations should continue to be required to provide all Medicare-covered benefits and services, but being able to manage *when, where,* and *how* to best deliver those benefits and services is absolutely critical to driving enhanced value of care management and better coordination to patients.

CMS is proposing to prohibit the ability of MA plans to use step therapy approaches in delivering Medicare-covered benefits (with the exception of Part B drugs). **Cigna opposes this proposal.** In some cases, step therapy may be appropriate, particularly in the context of transitions of care, where it is important to allow MA plans to use their evidence-based tools to appropriately optimize the site and length of service. MA organizations are well positioned to help coordinate and manage care and should be allowed the flexibility to do so.

MA plans should be permitted to deploy UM tools consistent with evidence-based medicine principles so that beneficiaries and the Medicare program receive and deliver truly value-based care. The scientific evidence supporting optimal health care decision making continues to evolve at an ever faster rate, and regulatory wording around how MA plans are permitted to incorporate new and evolving evidence in very dynamic spaces can have unintended consequences if not chosen very carefully. CMS historically recognizes this fact, which underpins the principles in the current criteria hierarchy requirements and allows MA plans the flexibility to fill in guidelines and criteria where the CMS manuals and determinations are not sufficiently specific to accurately assess an individual beneficiary's clinical scenario. Where the available peer-reviewed literature supports the delivery of care in a specific fashion to deliver optimal care for Medicare patients, MA plans should be able to use UM tools to support the same without having to seek specific requirements to this effect in statute, regulation or NCDs/LCDs. MA organizations are and have been partners with the Medicare program for the management of quality care for beneficiaries and the health care system. CMS should allow MA organizations flexibility to apply the latest, highest quality scientific evidence and continue to deliver value for program and patient needs.

2. *Continuity of Care (Section II.E.4.)*

CMS proposes to require that MA prior authorizations be valid for the duration of the entire approved prescribed or ordered course of treatment or service. CMS proposes to define "active course of treatment" as a course of treatment in which a patient is actively seeing a provider and following the prescribed or ordered course of treatment as outlined by the provider for a condition. In addition, CMS proposes to require MA organizations offering coordinated care plans to provide a 90-day transition period for any ongoing course of treatment when an enrollee has enrolled in an MA coordinated care plan after starting a course of treatment, even if it was commenced with an out-of-network provider.

Cigna Comments:

Cigna agrees it is important to guarantee a seamless transition of ongoing care when a beneficiary changes their coverage option under Medicare. We do this today in a number of

circumstances where it is considered most critical and where it is already required by Medicare law. The proposed language requiring approval for the entire ordered course of treatment has the unintended consequence of preventing any ongoing assessment of the treatment's effectiveness, or the opportunity to apply newer treatment options that recent evidence suggests may improve the beneficiary's health. However, Cigna is concerned that a 90-day transition period coverage requirement for *any* ongoing course of treatment is overly broad in scope. Moreover, we urge CMS to consider that Medicare-participating providers are not required to see MA beneficiaries unless the MA plan contracts with such providers. **If CMS finalizes this broad continuity of care policy for a 90-day transition period, we recommend that CMS require out-of-network providers to accept 100% of Medicare payment for such services.** This will minimize disruption and enable beneficiaries to continue care.

In addition, such a broad mandate would need to be facilitated by a manual and time-intensive process until such time as coverage determination information can flow more freely between health care entities, adding complexity, burden, and cost to the health care system. Consistent with the recommendation above, **Cigna recommends that this change not be implemented before January 1, 2026, to align with the Interoperability and Prior Authorization proposed rule timeline, and to allow MA plans to adjust their systems to the continuity of care changes.**

3. *Mandate Annual Review of UM Policies by a UM Committee (§ 422.137) (Subsection 5)*

CMS proposes that MA plans would be prohibited from using any utilization management policies for basic or supplemental benefits on or after January 1, 2024 unless those policies and procedures have been approved by the Utilization Management Committee. CMS proposes to require that MA organizations establish a Utilization Management Committee that is led by the plan's medical director, with specified requirements for the composition of the UM Committee. The Committee must document the reasons for its decisions. CMS would allow the Utilization Management Committee to operate similarly to the plan's Pharmacy and Therapeutics Committee, and to provide some flexibility to define the structure and responsibilities of the Utilization Management Committee.

Cigna Comments:

As a general matter, Cigna supports an administratively streamlined approach to the scope of Utilization Management Committee responsibilities, composition, and operational requirements. Heightened responsibilities and requirements have the potential to increase costs of operation and burden. Cigna emphasizes the importance of flexibility in the composition of the Utilization Management Committee and the manner in which it operates.

Allowing for plan discretion regarding the expertise of Utilization Management Committee members' needed for decisions and the nature of the backgrounds of the committee members will make administration of the committee's functions more streamlined. Furthermore, to the extent that utilization management policies remain consistent with existing statutes, regulations, NCDs and LCDs, and already appropriately established internal coverage criteria, Utilization Management Committees should not need to review and revise such policies annually.

Cigna appreciates CMS's reasonable approach to its proposed Utilization Management Committee composition and functions. As stated above, implementing the changes on a timeline that aligns with the Interoperability and Prior Authorization proposed rule implementation timeline would give MA plans sufficient time to prepare each of their Utilization Management Committees and

processes to comply. We also appreciate CMS' proposal to allow existing Pharmacy and Therapeutics Committees to take on this function, as it would reduce administrative complexity.

4. Additional Areas for Consideration and Comment: Gold Carding

CMS does not propose any change in regulation or guidance associated with gold-carding programs for MA plans. CMS states, however, that they "encourage MA plans to adopt gold-carding programs that would allow providers to be exempt from prior authorization and provide more streamlined medical necessity review processes for providers who have demonstrated compliance with plan requirements."

Cigna Comments:

Cigna seeks to ensure that appropriate care is delivered to patients in a simple, affordable, and predictable manner. Patients should receive clinically appropriate, evidence-based care, and to this end, prior authorization is one tool to align provider practices with clinical guidelines. Gold carding as a practice does not enhance medical care, but rather potentially creates a loophole for providers that results in higher levels of unnecessary care and increased health care system costs without a system of checks and balances to help ensure appropriate care and patient safety. We believe that gold carding practices inhibit improvement of provider performance and assurance that patients are being cared for using the most current evidence-based protocols; creating confusion and administrative burden.

Cigna commends CMS for allowing MA plans to exercise discretion about whether to implement gold carding programs. To the extent a provider organization takes on financial risk, or is delegated risk for prior authorization, from a health plan, gold carding may be appropriate and / or on a case-by-case basis.

D. Review of Medical Necessity Decisions by a Physician or Other Health Care Professional with Expertise in the Field of Medicine Appropriate to the Requested Service and Technical Correction to Effectuation Requirements for Standard Payment Reconsiderations (§§ 422.566, 422.590, and 422.629)

CMS is proposing to modify the existing organizational determination regulations by adding the requirement that the physician or other health care professional who conducts the initial review must have expertise in the field of medicine that is appropriate for the item or service being requested before the MA organization issues an adverse organization determination decision. CMS clarifies that under this proposal, the physician or other appropriate health care professional reviewing the request need not, in all cases, be of the same specialty or subspecialty as the treating physician or other health care provider. CMS seeks to align this proposal with the standards set forth in regulation related to the appropriate expertise applicable to physician review of *reconsiderations*. CMS expects MA organizations to apply the standard of "expertise appropriate for the specific service at issue" at the organization determination level in the same manner as plans have applied this standard at the reconsideration level.

Cigna Comments:

Cigna agrees that health care professionals making coverage decisions should have appropriate expertise in the context of reviews of medical necessity decisions. **We strongly support CMS' decision not to require the case reviewer involved to be of the exact same specialty or sub-specialty as the treating physician.** If a restrictive approach of this nature were required, it would be cost-prohibitive. Cigna strongly supports CMS' intent

to allow flexibility for a plan to determine on a case-by-case basis what constitutes appropriate expertise based on the services being requested and relevant aspects of the enrollee's health condition. **We urge CMS to modify the final regulatory text to make this flexibility and plan discretion clear.**

E. Updating Translation Standards for Required Materials and Content (§§ 422.2267 and 423.2267)

Current regulations require MA organizations and Part D plan sponsors to translate materials into any non-English language that is the primary language of at least five percent of individuals who reside in a plan benefit package service area. Each Fall, CMS posts languages that meet this threshold for every county in the US. CMS is proposing to require plans provide translated materials and auxiliary accessible formats upon request on a standing basis. CMS proposes to also extend this requirement to special needs plans (SNP) enrollee individualized care plans, and to require translation into any languages required by a Medicaid contract in addition to those required under Medicare for certain dual-eligible SNP types.

Cigna Comments:

Cigna supports CMS' goals to ensure to the accessibility of critical plan information and materials for all Medicare beneficiaries, regardless of language or need. We believe reasonable standards for ensuring this access are necessary, but we also express concerns over the significant cost and effort that would be required to meet the expanded nature of this proposal. For example, we believe it will be extremely difficult to turn around materials in some auxiliary aid formats, such as Braille, within the proposed short time frames, given the time required by our external contractors to do so. We anticipate this proposal will also further constrain our contracted vendors who work with multiple plans all subject to these new requirements, and we are concerned about reduced capacity. **We ask CMS to exercise flexibility on stringent turnaround time expectations for certain translation types (e.g., Braille) when plans make a good faith effort to respond to beneficiary requests.**

F. Medicare Advantage (MA) and Part D Marketing (Subpart V of Parts 422 and 423)

CMS is proposing numerous changes to the MA and Part D marketing regulations and guidelines to address concerns around marketing misrepresentation and beneficiary confusion. CMS' proposals generally can be categorized into two groups:

1. **Proposals to clarify permissible language and representations in marketing materials.** CMS is proposing new rules and additional clarity around the type of information and language that may and may not be used in plan materials and new rules around how information must be included and/or displayed in materials.

   Proposals to modify marketing activity and beneficiary interactions. CMS is proposing new rules and restrictions governing agent and broker activities and interaction with prospective enrollees, including required disclosures and limits on when outreach and communication may occur. CMS is also proposing additional rules on marketing by third-party marketing organizations (TPMOs) and plans' responsibilities to oversee that activity.

In general, CMS' proposals would become effective with the 2024 Plan Year (Fall 2023 annual election period [AEP] beginning on October 1, 2023). Further description of specific proposals and our comments follow below.

Cigna Comments:

Cigna agrees with CMS' assertion that beneficiaries should have access to complete, clear, and accurate information about their MA and Part D plan options that allows them to make an informed choice about their Medicare coverage and ensure they have the best plan to meet their needs. We agree beneficiaries must not be subject to misleading marketing or false information, but efforts to ensure complete and accurate information must not inadvertently make it more difficult or burdensome to get the information they need to make an informed choice. This includes access to representatives and licensed professionals who are best positioned to help beneficiaries understand what plan options are available to them and who can guide them through a sometimes complex enrollment process.

If finalized, these proposed rules would become effective for the 2024 Plan Year and AEP, which begins October 1. Depending on the timing of the publication of the final rule and any subsequent guidance, we are concerned that some proposals will not allow sufficient implementation time given the significant lead time required. **Cigna recommends CMS consider postponing the finalization of new sales and marketing regulations for the 2025 Plan Year / 2024 AEP.**

We offer additional feedback and recommendations on specific proposals below:

Proposals to Clarify Permissible Language and Representations in Marketing

- CMS is proposing to clarify when representations and logos of the Medicare name, CMS logo, and other official names and images may be used in MA marketing materials. CMS is proposing these changes to prevent their use in a "misleading" way. **Cigna supports this proposal, but we request additional clarity around permissible use, including examples showing when the use of names or images are acceptable and examples where they are "misleading."**

- CMS is proposing to further restrict the use of superlative statements unless supported by current data, with "current" defined as the current or previous plan year. **Cigna supports this proposal, but we request CMS provide additional clarity around permissible use, including additional examples to those contained in the proposed rule.**

- CMS is proposing to require certain disclaimers used in third-party marketing materials, including a list of all plans available by the seller and adding state health insurance programs (SHIPs) to the existing disclaimer. **Cigna supports CMS' proposal to provide clarity about what information to include and not include in marketing materials; however, as we state above, we ask CMS to consider implementing some changes for the 2025 Plan Year.** Given the timing of this proposed rule, and subsequent final rule and guidance, we are concerned there will be insufficient time for plans to update materials and obtain the necessary reviews and approvals by CMS in time for October 1 AEP.

- CMS is proposing to prohibit MA and Part D plans from including information about potential cost savings available to beneficiaries that are based on a comparison of typical expenses borne by uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a Medicare beneficiary. CMS is proposing this restriction to limit beneficiaries from being "enticed" about cost savings claims that may not be true. However, there is an often an objective, tangible cost benefit to individuals when comparing plan options or when comparing an MA plan to original Medicare. **While Cigna supports CMS' proposal to limit misleading statements**

that seek to entice beneficiaries, we request CMS confirm that certain cost comparisons remain permissible. We also suggest CMS consider specific required disclaimers or qualifiers when such comparisons are made.

Proposals to Modify Marketing Activities and Beneficiary Interactions

- CMS is proposing to prohibit marketing events from taking place within 12 hours of educational events in the same location. CMS explains this proposal is needed to give beneficiaries the option of leaving and not feeling pressured to attend the marketing event. While Cigna understands CMS' rationale for this proposal, we are concerned this restriction will create unnecessary barriers for beneficiaries, particularly those with transportation challenges or who live in rural communities. We also believe there are current guardrails in place to hold plans accountable to ensuring no beneficiary is pressured or misled into enrolling in a plan after an educational event (e.g., secret shopper programs, beneficiary complaints). **Cigna recommends CMS consider alternatives to this proposal. For example, CMS could require at least 30 minutes between events to give beneficiaries sufficient time to leave if they would like. CMS could also require a specific statement be made following educational events to clearly distinguish the two events, and to indicate that attendees may leave if they are not interested in the marketing event. Cigna opposes arbitrary restrictions that would create unnecessary barriers for certain beneficiaries and prevent them from engaging in appropriate marketing and enrollment events on the same day, in the same location.**

- CMS is proposing to reinstate the prohibition on accepting scope of appointment (SOA) cards and beneficiary contact information at educational events. CMS explains the purpose of this proposal is to address recent beneficiary complaints that *may* be partially a result of collecting this information at educational events. Cigna supports efforts to ensure the clarity and accuracy of information shared with beneficiaries about plan options. However, we believe a broad prohibition on collecting beneficiary contact information and SOAs at educational events is unnecessary and will inconvenience the beneficiary and add unnecessary complexity to the process of comparing Medicare coverage options. **Cigna recommends CMS not finalize this proposal.**

- CMS is proposing a new rule specifying that a beneficiary may only be contacted for six months after providing their contact information to a plan. Cigna believes this proposal will add unnecessary burden to beneficiaries by repeatedly being asked to opt into outreach. We also believe beneficiaries should be permitted to determine when and how they are contacted. **To that end, Cigna opposes this proposal and recommends CMS consider an alternative, such as requiring a statement or disclaimer reaffirming opt-out rights.**

- CMS is proposing to modify the pre-enrollment check list (PECL) to require a discussion of "effect on current coverage." CMS' rationale for this proposal is to address instances in which a beneficiary does not understand if enrolling in a specific plan will have an impact on their current coverage. Cigna agrees with CMS that beneficiaries should understand the impacts enrolling in a plan will have on their current coverage. However, we are concerned this proposal will require plan agents to have detailed knowledge of an individual's coverage that they may not have access to. **Cigna requests that CMS provide detailed guidance around specific scenarios that must be explained to meet this requirement, including the information about coverage implications in different scenarios.**

G. *Part D Medication Therapy Management (MTM) Program (§ 423.153(d))*

CMS is proposing to expand the eligibility criteria for receiving MTM services. Under current regulations, Part D plans are required to target beneficiaries for MTM programs if they have multiple chronic conditions, if they take multiple Part D-covered medications, and if they are expected to hit a certain level in Part D prescription drug costs in a given year. Plans currently have some discretion as to which chronic diseases to target. CMS' rationale for expanding the targeting criteria is to increase MTM program uptake rates, which it believes are too low.

CMS' specific proposals to expand MTM eligibility criteria are as follows:

- CMS is proposing to require plans to include *all* defined chronic conditions in their targeting criteria, rather than having the flexibility to target certain conditions. Current guidance defines nine specified core chronic conditions, and proposes to codify these nine in regulation, and to add HIV/AIDS to the list, for a new total of ten conditions. Plans would remain free to target beneficiaries beyond the core list or to include all diseases in their targeting criteria.
- CMS is proposing to lower the maximum number of covered Part D drugs beneficiaries be prescribed to be eligible from eight to five drugs. The changes make explicit that the definition of Part D drug for purposes of MTM eligibility includes all Part D maintenance drugs (as identified in "widely accepted, commercially or publicly available drug information databases" such as Medi-Span or First Databank). Plans would no longer be allowed to target only specific Part D drug classes.
- CMS is proposing to lower the cost threshold ($4,935 in 2023), which would now be based on the average annual cost of five generic prescriptions ($1,004 in 2020).

In total, CMS' proposals would significantly expand the population of beneficiaries that would be targeted by MTM programs.

Cigna Comments:

Cigna agrees with CMS that MTM is a critical tool in Part D to help manage the care of beneficiaries who are on complex and costly medication regimens. We believe MTM is of highest value when it is person-centered: provided at the right time, with the right level of intervention, to the right patient. While we appreciate CMS' efforts to expand these programs, we have significant concerns about the burdens and challenges plans and beneficiaries will face with this degree of expansion in a short time. We detail these concerns and additional comments below.

- **The proposal would de-value the benefit of MTM programs and introduce excess operational complexity too quickly.** First, the proposal would significantly increase the number of enrollees eligible for MTM. This would dilute plans' ability to target these interventions to those who would most benefit, and would siphon those resources to activities that provide less value and additional burden to beneficiaries. We believe this is in direct opposition to CMS' intent. Second, it would be difficult, if not impossible, to add the appropriate professional staff that would be needed to meet the new expansion requirements. And finally, the increased outreach and communication could frustrate beneficiaries who do not need or want MTM, and duplicate the efforts of MTM activities that are part of other care management programs an individual may be in. Increased abrasion with beneficiaries would likely lead to increased complaints.

- **Standalone Part D plans would face unique challenges.** As part of its proposal to expand the eligibility criteria to more conditions, CMS requests feedback on adding cancer to the list of targeted chronic conditions. Cancer treatment regimens, care

goals, and care patterns are extremely variable and complex. Part D plans do not have access to the level of medical data that would be needed to effectively target MTM programs; Part D (and even Part B) drug claims would be wholly insufficient to guide this process.

- **The proposal would negatively impact Stars.** In addition to operational considerations, the expansion in eligibility for MTM would negatively impact Star Ratings through performance on the MTM measure, and such an impact would likely apply industry wide. We have serious concerns about the overall impact to the MTM Stars measure and how it would interact with other Stars-related proposals in this rule (discussed later in these comments). Specifically, when combined with CMS' proposals to remove the cut point guardrails and eliminate the improvement standard, industry performance on the MTM measure will likely decline, resulting in even fewer resources available to meet the mandates of this expansion.

Because of these concerns, **Cigna strongly recommends CMS not finalize its proposal to expand MTM eligibility criteria in Part D at this time.** At a minimum, we urge CMS to delay any expansion until at least the 2025 plan year, phase in the expansion over several years, and consider moving the MTM measure to display only until the effects of expansion are understood.

Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (42 CFR 422.162, 422.164, 422.166, 422.260, 423.182, 423.184, and 423.186) (Section V)

CMS is proposing several updates and modifications to the MA and Part D Star Ratings system, including: adding, updating, or removing various measures; proposing several methodological changes; proposing a health equity index award factor; and proposing several technical changes to the policies around administration of the Star Ratings program. Cigna offers comments and recommendations on individual proposals contained throughout this section of the proposed rule below.

Cigna Comments:

Proposals to Modify Overall Star Ratings Methodology

- CMS proposes to reduce the weight of patient experience/complaints and access measures to further align the Part C and Part D Quality Rating System with other CMS programs. CMS previously increased the weight of these measures from 2x to 4x in a final rule published in June 2020. CMS explains that since then, it has received extensive stakeholder feedback and concerns with the decision to increase the weight of these measures, including a concern that it would disincentivize greater focus on measures related to patient outcomes, screenings, and preventive care. **Cigna strongly agrees with CMS' concerns and rationale.**

  Cigna strongly supports CMS' goal of reducing the weight of Access & Experience Star measures from 4 to 2 beginning with the 2026 Star Rating. Cigna values the voice of beneficiaries when evaluating the quality of care provided and places an emphasis on putting measures in place to improve customer experience. By increasing the value of data-driven evidence-based clinical measures and health outcomes in the total Star Rating, plans will be encouraged to prioritize and increase efforts to drive clinically appropriate care and promote health and safety. We believe this change will improve health outcomes long-term for Medicare beneficiaries as well as provide more stability in Star Rating outcomes.

- CMS proposes to limit the improvement hold harmless provision to 5 Star plans beginning with the 2026 Star Rating period. Under current regulations, 4.0- and 4.5-Star plans are also held harmless from the improvement measures, meaning that if a contract would have earned at least 4 Stars without the improvement measures, the overall contract Star Rating calculation would not include the improvement measures in the event that they would degrade the overall rating. This current policy aligns with CMS' quality standard for Quality Bonus Payments, which is also set at a minimum of 4 Stars as this broadly represents high performance. Cigna believes that if a contract genuinely performs at 4+ Stars (the CMS definition of high performance), even while facing a significant decline in measure performance from the prior year, it should not induce any penalties, especially penalties that could negatively impact plans' ability to offer robust benefits.

  Cigna also believes that limiting the improvement measure hold harmless provision to only 5-Star plans will further drive health equity disparities. Plan sponsors that manage a larger portion of customers with challenging health issues or issues related to SDOH may have a more difficult time achieving significant improvement when currently performing at a 4 or 4.5 Star level. Also, since the majority of measures that are included in the Part C and Part D improvement calculations are not case-mix adjusted (and Categorical Adjustment Index (CAI) is only applied at the summary rating level and the Health Equity Index (HEI) is also proposed to apply at the summary level), plan sponsors that grow within or expand into areas of need can find it particularly challenging to achieve significant improvements. Simply maintaining high performance while managing a high-risk population can result in little or no significant improvement for individual measures in the improvement calculation and can lead to earning a rating of 3 Stars on both 5-times weighted improvement measures, which then arbitrarily reduces the overall plan rating. Due to these reasons, **Cigna strongly believes that CMS should maintain the current improvement measure hold harmless provision which applies to contracts naturally earning a summary rating of 4 Stars or higher.**

- CMS proposes replacing the current Reward Factor with an HEI beginning with the 2027 Star Rating. The HEI would reward plans in instances where measure performance for beneficiaries with specific social risk factors, such as being a dual eligible or low-income subsidy (LIS), is similar to measure performance for beneficiaries without the social risk factors. Cigna commends CMS for its efforts to drive health equity across the diverse Medicare populations whom we jointly serve. Cigna offers the following recommendations regarding the HEI and Reward Factor Proposals:

  - **Cigna supports the continued research CMS is conducting on the impact of social risk factors on health outcomes and appreciates the further efforts to report data to plan sponsors stratified by important beneficiary subgroups.** CMS has developed the HEI and HEI Reward Factor as methodological enhancement to incentivize plan sponsors to focus quality improvements on socially at-risk beneficiaries. Cigna supports the development of the HEI and HEI Reward Factor as they align with our goals of improving health care quality for underserved and at-risk populations.

  - **We also support the retirement of the Reward Factor in favor of the more meaningful HEI Reward. However, we request that CMS publicly share the specific measures to be assessed as part of the HEI, such that plan sponsors are able to replicate CMS's calculations and conduct their own testing.** Currently, the proposed rule only provides examples of which measures would be included or excluded along with the general measure exclusion criteria. We request that additional details on methodology and results of the simulations performed using prior year Star data be provided to allow plans to better prepare for the proposed

change to the system.

- **Additionally, we request that CMS apply a phased-in approach for the new methodology whereas CMS would calculate both the Reward Factor and the HEI and apply a "better of" logic between the two for a period of two years before fully switching over to the HEI.**

- CMS proposes to eliminate 5% guardrails that were recently implemented to limit cut-point movement each year beginning with the 2026 Star Rating. Other cut-point adjustments including mean resampling and outlier removal using the Tukey Outer Fence model will remain in place. Cigna is concerned about the timing of making this change given the implementation of Tukey outlier deletion and mean resampling. We do not believe CMS or plans have sufficient experience or data to understand any unintended consequences of removing the guardrails, nor what impact that might have to predictability or stability in cut-points. **We encourage CMS to not finalize this change and consider reevaluating its proposal after we have more experience with Tukey and mean resampling.**

Proposals to Modify the Administration of the Star Ratings Program

- CMS proposes to codify that HEDIS[1], CAHPS[2], HOS[3], Part C & D Reporting Requirements, PDE[4], Medicare Plan Finder pricing files, data from the Medicare Beneficiary Suite of Systems, MARx[5] system, and other Federal Data Sources may not be used as the basis for a QBP[6] Reconsideration Administrative Review. Cigna is concerned this proposal will materially limit plan appeal rights, particularly the right for an administrative review, and will further limit CMS' discretion in reevaluating decisions made during the Plan Preview process. Cigna has experienced situations where some of these data sources were used as the basis for QBP Reconsideration Administrative Reviews. This has enabled CMS to reevaluate and appropriately overturn decisions the Agency made during the Stars Plan Preview. We are concerned this proposal will limit both plans and CMS in ensuring published Star Ratings are complete and accurate.

  Furthermore, we are concerned that "other Federal Data Sources" is a very broad term and may essentially negate the entire QBP Reconsideration Administrative Review process. **We encourage CMS not to finalize this proposal.**

- CMS proposes to revise a rule for non-substantive measure updates to add collection of survey data through another mode of survey administration to a list of non-substantive measure updates that can be made without rulemaking. **Cigna opposes CMS' proposal to add collection of survey data through another mode of survey administration to a list of non-substantive measure updates.** We are concerned that web-based respondents could create a source of bias in the data due to differences in socioeconomic factors, plan type, or geography and result in a material impact to contract performance. We recommend if a web-based mode of survey administration is added to mail and telephone, the change is considered substantive and performed through rulemaking. Additionally, we recommend this modality undergo consideration for inclusion in the case mix adjustment methodology for CAHPS and HOS administration based on observed differences. CMS proposes to expand the age range of the Colorectal Cancer Screening measure from 50-75 to 45-75, based on updated clinical recommendations and the National

[1] Healthcare Effectiveness Data and Information Set
[2] Consumer Assessment of Healthcare Providers and Systems
[3] Health Outcomes Survey
[4] Prescription Drug Event
[5] Medicare Advantage & Prescription Drug
[6] Quality Bonus Payment

Committee on Quality Assurance (NCQA) measure changes, for the 2026 Star year. The Colorectal Cancer Screening measure with its current age range will remain as a Star measure until then. **Cigna supports this proposal.**

Proposals to Add, Update, or Change Specific Measures

- CMS proposes to return Care for Older Adults – Functional Status Assessment as a Star for the 2026 Star year. The measure had been moved to display due to substantive specification changes. **Cigna supports this proposal.**

- CMS proposes to include risk adjustment based on sociodemographic status to the Medication Adherence measures (as recommended by the Pharmacy Quality Alliance [PQA]) for the 2028 Star year. Along with this change, CMS intends to remove these measures from CAI adjustment, align to the PQA continuous enrollment methodology, and remove adjustments for inpatient and skilled nursing facility (SNF) stays. CMS states that the addition of risk adjustment did not have a material impact to simulations they conducted using prior year Stars data, however removal from the CAI did have a marginal adverse impact to performance.

  Cigna generally agrees with CMS and PQA on the need to risk adjust medication adherence measures, at a minimum accounting for age, gender, dual eligibility/low-income subsidy status, and disability status. We also agree with the alignment to the PQA measure specifications for continuous enrollment during the treatment period instead of the current member-year methodology utilized by CMS. **However, Cigna strongly opposes the elimination of adjustments to the proportion of days covered (PDC) calculation, which accounts for days that a Medicare beneficiary is hospitalized or in a SNF stay.** Plan sponsors do not have the ability to impact medication adherence during an inpatient or SNF stay, and prescription claims for medications used during these stays are not included in the PDC calculation. Risk adjustment for socio-demographic factors does not directly account for inpatient or SNF stays and cannot serve as a substitute for this necessary adjustment. Exclusion of this adjustment to the PDC calculation may partially counteract what CMS is attempting to accomplish in measure equity through risk adjustment as it will have a larger impact to plans that manage medically higher-risk patients which often, but not always, have higher sociodemographic risks.

  Cigna also requests that CMS release additional details on the methodology for medication adherence risk adjustment beyond the framework provided by the PQA. For example, CMS should provide clear guidance on details such as whether the adjustments would be based on a current-year or prior-year risk model, and whether the risk model would be constructed using the beneficiary or the contract as the unit of analysis. We also strongly believe that CMS should create a risk adjustment process that is replicable by Part D sponsors such that it could be applied to internal claims data for real-time reporting.

  Cigna disagrees with CMS's proposal to apply the medication adherence risk adjustments only to the final set of Patient Safety Reports which are issued at the end of July after the measurement year has been completed. **We respectfully request that CMS instead provide monthly risk-adjusted beneficiary-level detail and contract summary data in the patient safety reports in order to provide ongoing transparency into the official risk-adjusted performance on the adherence measures. Finally, we request that CMS publicly release the results of the testing and simulations performed which are referred to in the proposed rule.**

- CMS proposes to add a single weighted Kidney Health Evaluation for Patients with Diabetes measure for the 2026 Star Rating year. The measure will replace the current Diabetes Care

– Kidney Disease Monitoring measure and will assess whether adults who have diabetes received an annual kidney profile evaluation, defined by an estimated Glomerular Filtration Rate (eGFR) and a Urine Albumin-Creatinine Ration (UACR) during the measurement year. Cigna appreciates CMS adding the KED metric to the Stars program in the future. **We support following clinical guidelines and adding newly developed measures that are clinically relevant to replace old measures such as Comprehensive Diabetes Care: Attention to Nephropathy.** We also appreciate CMS's approach to put this measure on display as plans gain experience and learn more about the performance of this measure.

- CMS is proposing to include three new Part D measures in the 2026 Star Ratings:
  - Concurrent Use of Opioids and Benzodiazepines (COB) (Part D) - analyzes the percentage of Medicare Part D beneficiaries 18 years and older with concurrent use of prescription opioids and benzodiazepines.
  - Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults (PolyACH) (Part D) - analyzes the percentage of Medicare Part D beneficiaries, 65 years or older, with concurrent use of two or more unique ACH medications during the measurement period.
  - Polypharmacy Use of Multiple Central Nervous System-Active Medications in Older Adults (Poly-CNS) (Part D) - analyzes the percentage of Medicare Part D beneficiaries, 65 years or older, with concurrent use of three or more unique CNS-active medications during the measurement period.

While these new measures are well-intended to help Part D plans better manage safety issues and potential abuse, we continue to have concerns about these measures, particularly the measures that include opioid medications in their specifications, being adopted in the Star Ratings program. We believe that including the two new measures which include opioid medications (COB and POLY-CNS) in the Star Rating program will have negative impacts on the perceived quality of care provided by plans solely based on them operating in geographic areas that are more heavily impacted by opioid abuse. This is especially significant where other SDOH, such as lower income and lower educational status, may also be present and creates an unbalanced playing field for plans operating in these areas. Additionally, this generates unnecessary headwinds for plans to earn quality bonus payments, keeping critical dollars away from plans that need funding for additional beneficiary services to help treat opioid-related issues. While CMS is planning to add the HEI to reward plans for managing beneficiaries with issues related to SDOH, we do not believe that it will adequately adjust to overcome the differences related to opioid use.

Cigna is also concerned about duplication and redundancy in these measures. Review of the 2023 CMS Display Measure specifications and medication lists shows that 97% of the medications included in the COB measure overlap with the medications also included in the POLY-CNS measure. Furthermore, analysis of the 2023 public Star Ratings Display data for the COB and POLY-CNS measures shows a statistical correlation between the two measures with approximately 44 percent of the contract-level observations being correlated. This demonstrates that plan sponsors may be penalized twice for the same set of opioid-using beneficiaries across these two measures. **For these reasons, we strongly believe the COB and POLY-CNS measures should not be included in the Star Ratings program.**

* * *

Confidential, unpublished property of The Cigna Group. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel. © 2023 The Cigna Group

TAB 21

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21244-1850

CENTER FOR MEDICARE

DATE: December 19, 2022

TO: All Part C and D Plan Sponsors

FROM: Amy Larrick Chavez-Valdez
Director, Medicare Drug Benefit and C & D Data Group

SUBJECT: Part C and D Star Ratings Tukey Outlier Deletion Simulations

In the final rule "Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program" (CMS-4190-F), published in the Federal Register on June 2, 2020 (the CY 2021 Final Rule)[1], CMS finalized the addition of Tukey outer fence outlier deletion to the clustering methodology beginning with the 2024 Part C and D Star Ratings. We finalized applying Tukey outlier deletion prior to mean resampling and hierarchical clustering for non- Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures and measures that have been in the Star Ratings program for more than three years (85 FR 33832–33836).

We are now providing simulations of Tukey outlier deletion with mean resampling and guardrails for the 2022 and 2023 Star Ratings. As we stated in the CY 2021 Final Rule, for the first year that Tukey outlier deletion is implemented (2024 Star Ratings), we will rerun the prior year's thresholds using mean resampling and Tukey outlier deletion so that guardrails will be applied consistently between years. Therefore, in the simulations, the 2022 Star Ratings thresholds were recalculated applying mean resampling and Tukey outlier deletion.

The Tukey outlier deletion simulations and Technical Notes are available to view on the CMS.gov website on this page: http://go.cms.gov/partcanddstarratings. Please email any questions on the Part C and D Star Ratings Tukey outlier deletion simulations to PartCandDStarRatings@cms.hhs.gov.

Thank you for your continued commitment to ensure the success of the Medicare Advantage and Prescription Drug programs.

[1] https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf

Technical Notes for Star Ratings Tukey Outlier Deletion Simulations

There are four tabs in the Tukey Outlier Deletion Simulations Excel file. The data on each tab are explained below. These simulations include identification of Tukey outer fence outliers which are defined as measure scores that are below a certain point (first quartile−3.0 × (third quartile−first quartile)) or above a certain point (third quartile + 3.0 × (third quartile−first quartile)).

Part C Outlier Cutoffs: This tab shows the simulated upper and lower Tukey outer fence outlier cutoffs for the 2022 and 2023 Star Ratings for each applicable Part C Star Ratings measure. If the calculated outlier cutoff is below the minimum or exceeds the maximum value for the given measure, then the minimum or maximum value is displayed as the cutoff.

Part D Outlier Cutoffs: This tab shows the simulated upper and lower Tukey outer fence outlier cutoffs for the 2022 and 2023 Star Ratings for each applicable Part D Star Ratings measure for each type of contract (MA-PD and PDP). If the calculated outlier cutoff is below the minimum or exceeds the maximum value for the given measure, then the minimum or maximum value is displayed as the cutoff.

2022 Star Ratings Cut Points: This tab shows two sets of cut points for the 2022 Star Ratings: (1) the actual cut points as calculated for the 2022 Star Ratings, and (2) simulated cut points for the 2022 Star Ratings calculated including Tukey outlier deletion. Neither set of cut points includes guardrails. The actual cut points are identified by 'Actual' in the 'Actual/Simulated Cut Points' column and blue highlighting, and the simulated cut points are identified by 'Simulated' in the 'Actual/Simulated Cut Points' column.

2023 Star Ratings Cut Points: This tab shows two sets of cut points for the 2023 Star Ratings: (1) the actual cut points as calculated for the 2023 Star Ratings including guardrails based on the actual 2022 Star Ratings cut points, (2) simulated cut points for the 2023 Star Ratings calculated including Tukey outlier deletion and guardrails based on the simulated 2022 Star Ratings cut points that included Tukey outlier deletion. The actual cut points are identified by 'Actual' in the 'Actual/Simulated Cut Points' column and blue highlighting, and the simulated cut points are identified by 'Simulated' in the 'Actual/Simulated Cut Points' column.

On both the 2022 Star Ratings Cut Points and 2023 Star Ratings Cut Points tabs, the four cut point thresholds are listed for each measure. These thresholds may be interpreted as shown in the following example for the actual 2023 Star Rating cut points for Breast Cancer Screening (C01).

- The 'Cut Point for 1 to 2 Stars' is 43. This means scores less than 43% correspond to 1 star.
- The 'Cut Point for 2 to 3 Stars' is 62. This means scores greater than or equal to 43% and less than 62% correspond to 2 stars.
- The 'Cut Point for 3 to 4 Stars' is 70. This means scores greater than or equal to 62% and less than 70% correspond to 3 stars.
- The 'Cut Point for 4 to 5 Stars' is 77. This means scores greater than or equal to 70% and less than 77% correspond to 4 stars, and scores greater than or equal to 77% correspond to 5 stars.

Star Ratings Year	2022 Star Ratings Measure ID	2023 Star Ratings Measure ID	Measure Name	Lower Outlier Cutoff	Upper Outlier Cutoff
2022	C01	C01	Breast Cancer Screening	34	100
2023	C01	C01	Breast Cancer Screening	29	100
2022	C02	C02	Colorectal Cancer Screening	35	100
2023	C02	C02	Colorectal Cancer Screening	31	100
2022	C04	C04	Monitoring Physical Activity	25	74
2023	C04	C04	Monitoring Physical Activity	25	74
2022	C05	C05	Special Needs Plan (SNP) Care Management	0	100
2023	C05	C05	Special Needs Plan (SNP) Care Management	0	100
2022	C06	C06	Care for Older Adults – Medication Review	51	100
2023	C06	C06	Care for Older Adults – Medication Review	58	100
2022	C07	C07	Care for Older Adults – Pain Assessment	61	100
2023	C07	C07	Care for Older Adults – Pain Assessment	57	100
2022	C08	C08	Osteoporosis Management in Women who had a Fracture	0	100
2023	C08	C08	Osteoporosis Management in Women who had a Fracture	0	100
2022	C09	C09	Diabetes Care – Eye Exam	26.5	100
2023	C09	C09	Diabetes Care – Eye Exam	27	100
2022	C10	C10	Diabetes Care – Kidney Disease Monitoring	84	100
2023	C10	C10	Diabetes Care – Kidney Disease Monitoring	85	100
2022	C11	C11	Diabetes Care – Blood Sugar Controlled	35	100
2023	C11	C11	Diabetes Care – Blood Sugar Controlled	49	100
2022	DMC	C12	Controlling Blood Pressure		
2023	DMC	C12	Controlling Blood Pressure	37	100
2022	C13	C13	Reducing the Risk of Falling	19	89
2023	C13	C13	Reducing the Risk of Falling	19	89
2022	C14	C14	Improving Bladder Control	24.5	66.5
2023	C14	C14	Improving Bladder Control	21	70
2022	C15	C15	Medication Reconciliation Post-Discharge	0	100
2023	C15	C15	Medication Reconciliation Post-Discharge	0	100
2022	C16	C16	Statin Therapy for Patients with Cardiovascular Disease	66	100
2023	C16	C16	Statin Therapy for Patients with Cardiovascular Disease	67	100
2022	C23	C23	Complaints about the Health Plan	0	0.79

Star Ratings Year	2022 Star Ratings Measure ID	2023 Star Ratings Measure ID	Measure Name	Lower Outlier Cutoff	Upper Outlier Cutoff
2023	C23	C23	Complaints about the Health Plan	0	1.12
2022	C24	C24	Members Choosing to Leave the Plan	0	62
2023	C24	C24	Members Choosing to Leave the Plan	0	71
2022	C26	C26	Plan Makes Timely Decisions about Appeals	80	100
2023	C26	C26	Plan Makes Timely Decisions about Appeals	84	100
2022	C27	C27	Reviewing Appeals Decisions	74	100
2023	C27	C27	Reviewing Appeals Decisions	77	100
2022	C28	C28	Call Center – Foreign Language Interpreter and TTY Availability	71	100
2023	C28	C28	Call Center – Foreign Language Interpreter and TTY Availability	50	100

Type of Contract	Star Ratings Year	2022 Star Ratings Measure ID	2023 Star Ratings Measure ID	Measure Name	Lower Outlier Cutoff	Upper Outlier Cutoff
MAPD	2022	D01	D01	Call Center – Foreign Language Interpreter and TTY Availability	74	100
MAPD	2023	D01	D01	Call Center – Foreign Language Interpreter and TTY Availability	42	100
MAPD	2022	D02	D02	Complaints about the Drug Plan	0	0.79
MAPD	2023	D02	D02	Complaints about the Drug Plan	0	1.12
MAPD	2022	D03	D03	Members Choosing to Leave the Plan	0	62
MAPD	2023	D03	D03	Members Choosing to Leave the Plan	0	71
MAPD	2022	D07	D07	MPF Price Accuracy	72	100
MAPD	2023	D07	D07	MPF Price Accuracy	67	100
MAPD	2022	D08	D08	Medication Adherence for Diabetes Medications	72	100
MAPD	2023	D08	D08	Medication Adherence for Diabetes Medications	72	100
MAPD	2022	D09	D09	Medication Adherence for Hypertension (RAS antagonists)	70	100
MAPD	2023	D09	D09	Medication Adherence for Hypertension (RAS antagonists)	74	100
MAPD	2022	D10	D10	Medication Adherence for Cholesterol (Statins)	69	100
MAPD	2023	D10	D10	Medication Adherence for Cholesterol (Statins)	69	100
MAPD	2022	D11	D11	MTM Program Completion Rate for CMR	46	100
MAPD	2023	D11	D11	MTM Program Completion Rate for CMR	49	100
MAPD	2022	D12	D12	Statin Use in Persons with Diabetes (SUPD)	69	97
MAPD	2023	D12	D12	Statin Use in Persons with Diabetes (SUPD)	67	100
PDP	2022	D01	D01	Call Center – Foreign Language Interpreter and TTY Availability	50	100
PDP	2023	D01	D01	Call Center – Foreign Language Interpreter and TTY Availability	74	100
PDP	2022	D02	D02	Complaints about the Drug Plan	0	0.25
PDP	2023	D02	D02	Complaints about the Drug Plan	0	0.34
PDP	2022	D03	D03	Members Choosing to Leave the Plan	0	45
PDP	2023	D03	D03	Members Choosing to Leave the Plan	0	30
PDP	2022	D07	D07	MPF Price Accuracy	68	100

Type of Contract	Star Ratings Year	2022 Star Ratings Measure ID	2023 Star Ratings Measure ID	Measure Name	Lower Outlier Cutoff	Upper Outlier Cutoff
PDP	2023	D07	D07	MPF Price Accuracy	70	100
PDP	2022	D08	D08	Medication Adherence for Diabetes Medications	76	97
PDP	2023	D08	D08	Medication Adherence for Diabetes Medications	76	97
PDP	2022	D09	D09	Medication Adherence for Hypertension (RAS antagonists)	78	99
PDP	2023	D09	D09	Medication Adherence for Hypertension (RAS antagonists)	82	96
PDP	2022	D10	D10	Medication Adherence for Cholesterol (Statins)	77	98
PDP	2023	D10	D10	Medication Adherence for Cholesterol (Statins)	77	98
PDP	2022	D11	D11	MTM Program Completion Rate for CMR	0	100
PDP	2023	D11	D11	MTM Program Completion Rate for CMR	0	100
PDP	2022	D12	D12	Statin Use in Persons with Diabetes (SUPD)	70	91
PDP	2023	D12	D12	Statin Use in Persons with Diabetes (SUPD)	72	93

Type of Contract	Actual/Simulated Cut Points	Tukey Outlier Deletion	2022 Star Ratings Measure ID	Measure Name	Cut Point for 1 to 2 Stars	Cut Point for 2 to 3 Stars	Cut Point for 3 to 4 Stars	Cut Point for 4 to 5 Stars
MA	Simulated	Yes	C01	Breast Cancer Screening	58	67	73	78
MA	Actual	No	C01	Breast Cancer Screening	38	61	69	76
MA	Simulated	Yes	C02	Colorectal Cancer Screening	55	66	73	80
MA	Actual	No	C02	Colorectal Cancer Screening	48	62	71	80
MA	Simulated	Yes	C04	Monitoring Physical Activity	42	47	52	57
MA	Actual	No	C04	Monitoring Physical Activity	42	47	52	57
MA	Simulated	Yes	C05	Special Needs Plan (SNP) Care Management	45	59	73	87
MA	Actual	No	C05	Special Needs Plan (SNP) Care Management	45	59	73	87
MA	Simulated	Yes	C06	Care for Older Adults – Medication Review	68	80	88	96
MA	Actual	No	C06	Care for Older Adults – Medication Review	48	71	84	95
MA	Simulated	Yes	C07	Care for Older Adults – Pain Assessment	77	87	92	96
MA	Actual	No	C07	Care for Older Adults – Pain Assessment	55	76	87	96
MA	Simulated	Yes	C08	Osteoporosis Management in Women who had a Fracture	27	40	50	68
MA	Actual	No	C08	Osteoporosis Management in Women who had a Fracture	27	40	50	68
MA	Simulated	Yes	C09	Diabetes Care – Eye Exam	53	63	72	79
MA	Actual	No	C09	Diabetes Care – Eye Exam	52	62	71	79
MA	Simulated	Yes	C10	Diabetes Care – Kidney Disease Monitoring	92	94	96	97
MA	Actual	No	C10	Diabetes Care – Kidney Disease Monitoring	75	88	94	97
MA	Simulated	Yes	C11	Diabetes Care – Blood Sugar Controlled	58	69	77	84
MA	Actual	No	C11	Diabetes Care – Blood Sugar Controlled	40	60	72	81
MA	Simulated	Yes	C13	Reducing the Risk of Falling	48	54	61	70
MA	Actual	No	C13	Reducing the Risk of Falling	48	55	64	72
MA	Simulated	Yes	C14	Improving Bladder Control	42	45	49	53
MA	Actual	No	C14	Improving Bladder Control	42	45	49	53
MA	Simulated	Yes	C15	Medication Reconciliation Post-Discharge	39	56	69	82
MA	Actual	No	C15	Medication Reconciliation Post-Discharge	39	56	69	82
MA	Simulated	Yes	C16	Statin Therapy for Patients with Cardiovascular Disease	76	81	84	89
MA	Actual	No	C16	Statin Therapy for Patients with Cardiovascular Disease	76	81	84	89
MA	Simulated	Yes	C23	Complaints about the Health Plan	0.46	0.31	0.17	0.08
MA	Actual	No	C23	Complaints about the Health Plan	1.39	0.81	0.37	0.17
MA	Simulated	Yes	C24	Members Choosing to Leave the Plan	37	26	16	8

Type of Contract	Actual/Simulated Cut Points	Tukey Outlier Deletion	2022 Star Ratings Measure ID	Measure Name	Cut Point for 1 to 2 Stars	Cut Point for 2 to 3 Stars	Cut Point for 3 to 4 Stars	Cut Point for 4 to 5 Stars
MA	Actual	No	C24	Members Choosing to Leave the Plan	44	29	16	9
MA	Simulated	Yes	C26	Plan Makes Timely Decisions about Appeals	86	91	96	98
MA	Actual	No	C26	Plan Makes Timely Decisions about Appeals	64	80	90	97
MA	Simulated	Yes	C27	Reviewing Appeals Decisions	83	90	95	98
MA	Actual	No	C27	Reviewing Appeals Decisions	65	84	91	96
MA	Simulated	Yes	C28	Call Center – Foreign Language Interpreter and TTY Availability	81	87	94	100
MA	Actual	No	C28	Call Center – Foreign Language Interpreter and TTY Availability	31	54	78	94
MAPD	Simulated	Yes	D01	Call Center – Foreign Language Interpreter and TTY Availability	84	89	94	97
MAPD	Actual	No	D01	Call Center – Foreign Language Interpreter and TTY Availability	25	59	84	94
MAPD	Simulated	Yes	D02	Complaints about the Drug Plan	0.46	0.31	0.17	0.08
MAPD	Actual	No	D02	Complaints about the Drug Plan	1.39	0.81	0.37	0.17
MAPD	Simulated	Yes	D03	Members Choosing to Leave the Plan	37	26	16	8
MAPD	Actual	No	D03	Members Choosing to Leave the Plan	44	29	16	9
MAPD	Simulated	Yes	D07	MPF Price Accuracy	78	87	91	96
MAPD	Actual	No	D07	MPF Price Accuracy	73	83	91	96
MAPD	Simulated	Yes	D08	Medication Adherence for Diabetes Medications	81	85	88	92
MAPD	Actual	No	D08	Medication Adherence for Diabetes Medications	80	85	87	91
MAPD	Simulated	Yes	D09	Medication Adherence for Hypertension (RAS antagonists)	81	85	88	90
MAPD	Actual	No	D09	Medication Adherence for Hypertension (RAS antagonists)	73	82	87	90
MAPD	Simulated	Yes	D10	Medication Adherence for Cholesterol (Statins)	80	84	88	92
MAPD	Actual	No	D10	Medication Adherence for Cholesterol (Statins)	78	83	87	91
MAPD	Simulated	Yes	D11	MTM Program Completion Rate for CMR	66	76	83	89
MAPD	Actual	No	D11	MTM Program Completion Rate for CMR	52	72	82	89
MAPD	Simulated	Yes	D12	Statin Use in Persons with Diabetes (SUPD)	76	81	84	88
MAPD	Actual	No	D12	Statin Use in Persons with Diabetes (SUPD)	76	80	84	88
PDP	Simulated	Yes	D01	Call Center – Foreign Language Interpreter and TTY Availability	80	89	94	100
PDP	Actual	No	D01	Call Center – Foreign Language Interpreter and TTY Availability	55	78	88	97

Type of Contract	Actual/Simulated Cut Points	Tukey Outlier Deletion	2022 Star Ratings Measure ID	Measure Name	Cut Point for 1 to 2 Stars	Cut Point for 2 to 3 Stars	Cut Point for 3 to 4 Stars	Cut Point for 4 to 5 Stars
PDP	Simulated	Yes	D02	Complaints about the Drug Plan	0.14	0.08	0.04	0.01
PDP	Actual	No	D02	Complaints about the Drug Plan	0.31	0.19	0.1	0.03
PDP	Simulated	Yes	D03	Members Choosing to Leave the Plan	21	14	9	6
PDP	Actual	No	D03	Members Choosing to Leave the Plan	21	14	9	6
PDP	Simulated	Yes	D07	MPF Price Accuracy	84	88	94	97
PDP	Actual	No	D07	MPF Price Accuracy	84	88	94	97
PDP	Simulated	Yes	D08	Medication Adherence for Diabetes Medications	84	86	88	90
PDP	Actual	No	D08	Medication Adherence for Diabetes Medications	84	86	88	90
PDP	Simulated	Yes	D09	Medication Adherence for Hypertension (RAS antagonists)	85	88	89	91
PDP	Actual	No	D09	Medication Adherence for Hypertension (RAS antagonists)	85	88	89	91
PDP	Simulated	Yes	D10	Medication Adherence for Cholesterol (Statins)	84	87	88	90
PDP	Actual	No	D10	Medication Adherence for Cholesterol (Statins)	82	86	88	90
PDP	Simulated	Yes	D11	MTM Program Completion Rate for CMR	31	46	61	73
PDP	Actual	No	D11	MTM Program Completion Rate for CMR	31	46	61	73
PDP	Simulated	Yes	D12	Statin Use in Persons with Diabetes (SUPD)	77	79	82	84
PDP	Actual	No	D12	Statin Use in Persons with Diabetes (SUPD)	77	79	82	84

Type of Contract	Actual/Simulated Cut Points	Tukey Outlier Deletion	Guardrails	2022 Star Ratings Measure ID	2023 Star Ratings Measure ID	Measure Name	Cut Point for 1 to 2 Stars	Cut Point for 2 to 3 Stars	Cut Point for 3 to 4 Stars	Cut Point for 4 to 5 Stars
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C01	C01	Breast Cancer Screening	53	63	71	76
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C01	C01	Breast Cancer Screening	43	62	70	77
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C02	C02	Colorectal Cancer Screening	55	66	74	81
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C02	C02	Colorectal Cancer Screening	43	60	71	79
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C04	C04	Monitoring Physical Activity	44	49	53	57
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C04	C04	Monitoring Physical Activity	44	49	53	57
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C05	C05	Special Needs Plan (SNP) Care Management	46	62	75	85
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C05	C05	Special Needs Plan (SNP) Care Management	46	62	75	85
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C06	C06	Care for Older Adults – Medication Review	73	82	91	96
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C06	C06	Care for Older Adults – Medication Review	43	70	82	93
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C07	C07	Care for Older Adults – Pain Assessment	73	83	89	95
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C07	C07	Care for Older Adults – Pain Assessment	50	71	85	94
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C08	C08	Osteoporosis Management in Women who had a Fracture	32	45	55	73
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C08	C08	Osteoporosis Management in Women who had a Fracture	32	45	55	73
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C09	C09	Diabetes Care – Eye Exam	48	61	71	79
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C09	C09	Diabetes Care – Eye Exam	47	61	71	79
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C10	C10	Diabetes Care – Kidney Disease Monitoring	92	95	97	99
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C10	C10	Diabetes Care – Kidney Disease Monitoring	80	93	95	97
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C11	C11	Diabetes Care – Blood Sugar Controlled	63	72	80	86
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C11	C11	Diabetes Care – Blood Sugar Controlled	39	62	75	83
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	DMC	C12	Controlling Blood Pressure	61	69	75	82
MA	Actual	No	Based on 2022 Star Ratings cutpoints	DMC	C12	Controlling Blood Pressure	48	63	73	80
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C13	C13	Reducing the Risk of Falling	46	53	60	69
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C13	C13	Reducing the Risk of Falling	46	53	60	69
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C14	C14	Improving Bladder Control	39	43	48	53
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C14	C14	Improving Bladder Control	39	43	48	53
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C15	C15	Medication Reconciliation Post-Discharge	43	57	69	82
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C15	C15	Medication Reconciliation Post-Discharge	43	57	69	82
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C16	C16	Statin Therapy for Patients with Cardiovascular Disease	79	84	86	89
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C16	C16	Statin Therapy for Patients with Cardiovascular Disease	75	81	85	89
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C23	C23	Complaints about the Health Plan	0.6	0.43	0.25	0.12
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C23	C23	Complaints about the Health Plan	1.53	0.89	0.5	0.19
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C24	C24	Members Choosing to Leave the Plan	37	24	15	7
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C24	C24	Members Choosing to Leave the Plan	39	24	15	7
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C26	C26	Plan Makes Timely Decisions about Appeals	89	93	97	100
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C26	C26	Plan Makes Timely Decisions about Appeals	59	75	85	97
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C27	C27	Reviewing Appeals Decisions	84	90	95	98
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C27	C27	Reviewing Appeals Decisions	68	83	91	97
MA	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	C28	C28	Call Center – Foreign Language Interpreter and TTY Availability	76	82	89	95
MA	Actual	No	Based on 2022 Star Ratings cutpoints	C28	C28	Call Center – Foreign Language Interpreter and TTY Availability	36	59	83	94
MAPD	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D01	D01	Call Center – Foreign Language Interpreter and TTY Availability	68	81	91	97
MAPD	Actual	No	Based on 2022 Star Ratings cutpoints	D01	D01	Call Center – Foreign Language Interpreter and TTY Availability	30	64	80	91
MAPD	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D02	D02	Complaints about the Drug Plan	0.68	0.43	0.25	0.12

Type of Contract	Actual/Simulated Cut Points	Tukey Outlier Deletion	Guardrails	2022 Star Ratings Measure ID	2023 Star Ratings Measure ID	Measure Name	Cut Point for 1 to 2 Stars	Cut Point for 2 to 3 Stars	Cut Point for 3 to 4 Stars	Cut Point for 4 to 5 Stars
MAPD	Actual	No	Based on 2022 Star Ratings cutpoints	D02	D02	Complaints about the Drug Plan	1.53	0.89	0.5	0.19
MAPD	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D03	D03	Members Choosing to Leave the Plan	37	24	15	7
MAPD	Actual	No	Based on 2022 Star Ratings cutpoints	D03	D03	Members Choosing to Leave the Plan	39	24	15	7
MAPD	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D07	D07	MPF Price Accuracy	87	91	95	99
MAPD	Actual	No	Based on 2022 Star Ratings cutpoints	D07	D07	MPF Price Accuracy	72	86	93	97
MAPD	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D08	D08	Medication Adherence for Diabetes Medications	81	85	88	92
MAPD	Actual	No	Based on 2022 Star Ratings cutpoints	D08	D08	Medication Adherence for Diabetes Medications	79	85	88	92
MAPD	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D09	D09	Medication Adherence for Hypertension (RAS antagonists)	83	86	89	91
MAPD	Actual	No	Based on 2022 Star Ratings cutpoints	D09	D09	Medication Adherence for Hypertension (RAS antagonists)	78	86	89	91
MAPD	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D10	D10	Medication Adherence for Cholesterol (Statins)	81	85	88	92
MAPD	Actual	No	Based on 2022 Star Ratings cutpoints	D10	D10	Medication Adherence for Cholesterol (Statins)	81	85	88	92
MAPD	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D11	D11	MTM Program Completion Rate for CMR	68	78	84	91
MAPD	Actual	No	Based on 2022 Star Ratings cutpoints	D11	D11	MTM Program Completion Rate for CMR	47	67	82	89
MAPD	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D12	D12	Statin Use in Persons with Diabetes (SUPD)	80	84	86	90
MAPD	Actual	No	Based on 2022 Star Ratings cutpoints	D12	D12	Statin Use in Persons with Diabetes (SUPD)	80	84	86	90
PDP	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D01	D01	Call Center – Foreign Language Interpreter and TTY Availability	86	92	97	100
PDP	Actual	No	Based on 2022 Star Ratings cutpoints	D01	D01	Call Center – Foreign Language Interpreter and TTY Availability	60	75	91	97
PDP	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D02	D02	Complaints about the Drug Plan	0.15	0.1	0.07	0.03
PDP	Actual	No	Based on 2022 Star Ratings cutpoints	D02	D02	Complaints about the Drug Plan	0.34	0.22	0.13	0.06
PDP	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D03	D03	Members Choosing to Leave the Plan	18	13	9	5
PDP	Actual	No	Based on 2022 Star Ratings cutpoints	D03	D03	Members Choosing to Leave the Plan	23	16	11	7
PDP	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D07	D07	MPF Price Accuracy	90	94	96	99
PDP	Actual	No	Based on 2022 Star Ratings cutpoints	D07	D07	MPF Price Accuracy	90	94	96	99
PDP	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D08	D08	Medication Adherence for Diabetes Medications	84	86	88	90
PDP	Actual	No	Based on 2022 Star Ratings cutpoints	D08	D08	Medication Adherence for Diabetes Medications	84	86	88	90
PDP	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D09	D09	Medication Adherence for Hypertension (RAS antagonists)	86	88	89	91
PDP	Actual	No	Based on 2022 Star Ratings cutpoints	D09	D09	Medication Adherence for Hypertension (RAS antagonists)	86	89	91	96
PDP	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D10	D10	Medication Adherence for Cholesterol (Statins)	86	87	88	90
PDP	Actual	No	Based on 2022 Star Ratings cutpoints	D10	D10	Medication Adherence for Cholesterol (Statins)	84	87	88	90
PDP	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D11	D11	MTM Program Completion Rate for CMR	34	49	62	78
PDP	Actual	No	Based on 2022 Star Ratings cutpoints	D11	D11	MTM Program Completion Rate for CMR	34	49	62	78
PDP	Simulated	Yes	Based on simulated 2022 Star Ratings cutpoints with Tukey outlier deletion	D12	D12	Statin Use in Persons with Diabetes (SUPD)	80	82	84	86
PDP	Actual	No	Based on 2022 Star Ratings cutpoints	D12	D12	Statin Use in Persons with Diabetes (SUPD)	80	82	84	86

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SCAN HEALTH PLAN, *Plaintiff*, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	Case No. 1:23-cv-3910-CJN

JOINT APPENDIX

VOLUME II

Tabs 22 – 23 (Pt. 1)

Adjudication Record ("A.R.")

Tab	Document Description	A.R. Page Range
22	Hearing Officer's Decision	SCAN-AR00001 – 00007
23 (Pt. 1)	CMS's Submission to the Hearing Officer	SCAN-AR00008 – 00202

TAB 22

From: Tabe-Bedward, Arrah (CMS/CMMI)
To: CMS QBPAPPEALS
Cc: Renee Delphin-Rodriguez; Michael Plumb
Subject: RE: QBP Informal Hearing Request Form for SCAN Health Plan (H5425)
Date: Monday, March 25, 2024 4:30:14 PM
Attachments: QBP Appeals_OTR Hearing_SCAN_03222024.pdf

Michael Plumb
CFO, SCAN Health Plan

Dear Mr. Plumb,

Please find attached the Hearing Decision Upholding CMS's denial of SCAN's Appeal of its 2025 Quality Bonus Payment Rating.

Thank you,

Arrah Tabe-Bedward

From: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Sent: Tuesday, March 12, 2024 4:32 PM
To: Tabe-Bedward, Arrah (CMS/CMMI) <arrah.tabebedward@cms.hhs.gov>
Cc: Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>; Michael Plumb <MPlumb@scanhealthplan.com>; CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Subject: RE: QBP Informal Hearing Request Form for SCAN Health Plan (H5425)

Arrah Tabe-Bedward, Hearing Officer
Deputy Director, Center for Medicare and Medicaid Innovation

Dear Ms. Tabe-Bedward,

Please find attached CMS's Memorandum in Support of Denial of SCAN's Appeal of its 2025 Quality Bonus Payment Rating and other supporting documents, including documentary evidence submitted by SCAN for contract H5425. Please send your decision to everyone copied on this email.

Thank you,
CMS Star Ratings team

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Thursday, February 29, 2024 3:06 PM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Cc: Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: RE: QBP Informal Hearing Request Form for SCAN Health Plan (H5425)

Just in case it is necessary for proper consideration of our informal hearing request, we have also

attached here a second version (Attachment B-Informal Hearing_Form_2025 SCAN Health Plan H5245 v2) that includes our justification on the "Additional Comments" section of the form, rather than just in an attached Microsoft Word document. We had to insert two additional rows since it did not fit in the one row in the original form.

Please confirm receipt.

From: Michael Plumb
Sent: Thursday, February 29, 2024 10:43 AM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Cc: Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: QBP Informal Hearing Request Form for SCAN Health Plan (H5425)

Attached please find SCAN Health Plan's Request for an Informal Hearing for MAPD contract H5425. Please note that in addition to the Informal Hearing Request form (excel file), we have attached several additional documents:

- A Microsoft Word file that contains our reasoning for the request for the informal hearing, since it does not fit in the cell for "Additional Comments" in the Excel Form in row 69 [
- The email request for reconsideration submitted on November 9th, 2023, which included the following:
  - Excel based request for reconsideration form
  - A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text pasted into the Excel form).
  - An additional file (.wav format) that includes a recording of a call (#C1201277) that we referenced in our justification for reconsideration.
- An additional ZIP file that contains the ".wav" format recording of the call (#C0600900) that is the focus for our appeal.
- A certified translation of call #C0600900, the call we are appealing
- A certified translation of call #C1201277, a reference call that is included in our appeal justification

Please let us know if you have any questions, or if you have any issues opening any of the files given the size of this email. I know there was some difficulty previously opening the .wav file.

Also, to ensure CMS receipt of this request for an informal hearing, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Friday, November 10, 2023 12:14 AM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>

Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: QBP Reconsideration Form for SCAN Health Plan (H5425)

Attached please find SCAN Health Plan's Request for Reconsideration for MAPD contract H5425. Please note that in addition to the Excel form, we have attached two additional forms:

- An additional file (.wav format) that includes a recording of a call that we referenced in our justification for reconsideration.
- A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text pasted into the Excel form).

Please let us know if you have any questions.

Also, to ensure CMS receipt of this request for reconsideration, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

March 25, 2024

Centers for Medicare & Medicaid Services
Hearing Officer Decision

In the Matter of: Informal Hearing Decision for Contract H5425

Dear Mr. Plumb:

The following represents the hearing officer decision in response to SCAN Health Plan's (SCAN's) request for an informal hearing on the record for the 2024 Star Ratings and associated 2025 Quality Bonus Payment ("QBP") determination for Contract H5425.

Introduction

Pursuant to 42 C.F.R. § 422.260, Medicare Advantage ("MA") organizations are provided an opportunity to request a reconsideration of a QBP determination. Should the MA organization receive an adverse reconsideration decision, the organization may request an informal hearing on the record. Administrative review may not be requested to contest the methodology for calculating the star ratings, the cut-off points for determining measure thresholds, the set of measures included in calculating star ratings, and the methodology for QBP determinations for low enrollment contracts or new MA plans. 42 C.F.R. § 422.260(c)(3)(ii). Informal hearing requests are limited to the measure(s) and value(s) that precipitated the request for reconsideration. 42 C.F.R. § 422.260(c)(2)(iii). Finally, the MA organization must provide clear and convincing evidence that CMS' calculations were incorrect. 42 C.F.R. § 422.260(c)(2)(v).

SCAN requested a reconsideration of its 2025 QBP determination and a decision was rendered by the CMS Reconsideration Official on February 22, 2024, which upheld the initial determination. SCAN has now requested an informal hearing, arguing that there was a technical issue caused by the CMS caller that ultimately caused the call to exceed the 8-minute threshold. As a result, call C0600900 should either be reclassified as successful ("completed") or taken out of the calculation for the C30 Star Rating measure.

Findings of Fact and Conclusions of Law

As iterated above, administrative review is limited to possible calculation errors or inaccuracies in the data utilized for determining star ratings. 42 C.F.R. § 422.260(c)(3)(ii). A reconsideration or informal hearing is not the proper venue for contesting the methodology or the set of measures included in calculating the star ratings. *Id*.

SCAN asserts that call C0600900 exceeded the 8-minute threshold because the CMS caller asked the question in a non-standard way which caused confusion for the interpreter and resulted in a 34 second delay. SCAN further asserts that although it took 6 minutes and 35 seconds to get an interpreter on the line, the remaining 1 minute and 25 seconds is enough time for the CMS caller to ask the standard question and get the appropriate response from the customer service representative. SCAN references another French call (C1201277) received on March 24,2023 to support this assertion.

SCAN also asserts that because an interpreter was available within 6 minutes and 35 seconds of call C0600900 it satisfied the requirement in the relevant regulations at 42 C.F.R. §§ 422.111(h) which state that "interpreters must be available for 80 percent of incoming calls requiring an interpreter within 8 minutes of reaching the customer service representative".

SCAN is appealing both the determination that the CMS caller's question was appropriate and accurate, and the accuracy of the resulting determination that the plan exceeded the 8-minute threshold to confirm it can answer questions about the plan benefits.

SCAN is contesting CMS' inclusion of call C0600900 in the data set used to calculate Contract H5425's 2024 Star Rating for measure C30 and its associated 2025 QBP rating. SCAN asserts that call C0600900 should either be counted as "successful" or excluded from the measure.

As the hearing officer for this request, I reviewed and considered all of the supporting details for the plan's informal hearing on the record request, including the QBP determination, the evidence and findings upon which the initial determination was based, and the additional information submitted by SCAN. I find that SCAN has not demonstrated by a clear and convincing evidence standard that CMS either used incorrect data or made a calculation error by including call C0600900 in the data set for calculating measure C30 for Contract H5425.

As noted on page 6 of the February 22, 2024, CMS Reconsideration "the purpose of these test calls is to replicate the experience prospective members would have if they called the plan's toll-free number. How prospective members ask a question will differ from call to call". Even with the long pauses noted by SCAN, it took the CMS caller just 25 seconds to ask the question, which is a fraction of the 8-minute threshold.

Additionally, while 42 C.F.R. §§ 422.111(h) establishes the 8-minute measure for interpreter availability, CMS in the December 1, 2022, Call Center Monitoring HPMS memo defines interpreter availability and when the 8-minute measure is met: "Interpreter availability is defined as the ability of a caller to communicate with someone and receive answers to questions in the caller's language. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits . . . A call is considered connected when the caller reaches a CSR. *The measure is considered completed when the caller confirms that the CSR is able to answer questions about plan benefits via an interpreter* (before beginning the first of three general Medicare or plan-specific accuracy questions) *within eight minutes* (emphasis added).

Decision

The reconsideration official's determination is upheld and CMS will not change the QBP rating for Contract H5425. This decision is final and binding on both the MA organization and CMS.

Sincerely,

Arrah Tabe-Bedward, CMS Hearing Officer
Deputy Director, Center for Medicare and Medicaid Innovation

TAB 23
(Part 1)

From:	CMS QBPAPPEALS
To:	Tabe-Bedward, Arrah (CMS/CMMI)
Cc:	Renee Delphin-Rodriguez; Michael Plumb; CMS QBPAPPEALS
Subject:	RE: QBP Informal Hearing Request Form for SCAN Health Plan (H5425)
Date:	Tuesday, March 12, 2024 4:32:09 PM
Attachments:	Informal Hearing SCAN H5425 - CMS Memo to Deny.pdf SCAN Exhibits.zip

Arrah Tabe-Bedward, Hearing Officer
Deputy Director, Center for Medicare and Medicaid Innovation

Dear Ms. Tabe-Bedward,

Please find attached CMS's Memorandum in Support of Denial of SCAN's Appeal of its 2025 Quality Bonus Payment Rating and other supporting documents, including documentary evidence submitted by SCAN for contract H5425. Please send your decision to everyone copied on this email.

Thank you,
CMS Star Ratings team

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Thursday, February 29, 2024 3:06 PM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Cc: Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: RE: QBP Informal Hearing Request Form for SCAN Health Plan (H5425)

Just in case it is necessary for proper consideration of our informal hearing request, we have also attached here a second version (Attachment B-Informal Hearing_Form_2025 SCAN Health Plan H5245 v2) that includes our justification on the "Additional Comments" section of the form, rather than just in an attached Microsoft Word document. We had to insert two additional rows since it did not fit in the one row in the original form.

Please confirm receipt.

From: Michael Plumb
Sent: Thursday, February 29, 2024 10:43 AM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Cc: Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: QBP Informal Hearing Request Form for SCAN Health Plan (H5425)

Attached please find SCAN Health Plan's Request for an Informal Hearing for MAPD contract H5425. Please note that in addition to the Informal Hearing Request form (excel file), we have attached several additional documents:

- A Microsoft Word file that contains our reasoning for the request for the informal hearing, since it does not fit in the cell for "Additional Comments" in the Excel Form in row 69 [

th

The email request for reconsideration submitted on November 9 , 2023, which included the following:

- Excel based request for reconsideration form
- A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text pasted into the Excel form).
- An additional file (.wav format) that includes a recording of a call (#C1201277) that we referenced in our justification for reconsideration.

- An additional ZIP file that contains the ".wav" format recording of the call (#C0600900) that is the focus for our appeal.
- A certified translation of call #C0600900, the call we are appealing
- A certified translation of call #C1201277, a reference call that is included in our appeal justification

Please let us know if you have any questions, or if you have any issues opening any of the files given the size of this email. I know there was some difficulty previously opening the .wav file.

Also, to ensure CMS receipt of this request for an informal hearing, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Friday, November 10, 2023 12:14 AM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: QBP Reconsideration Form for SCAN Health Plan (H5425)

Attached please find SCAN Health Plan's Request for Reconsideration for MAPD contract H5425. Please note that in addition to the Excel form, we have attached two additional forms:

- An additional file (.wav format) that includes a recording of a call that we referenced in our justification for reconsideration.
- A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text pasted into the Excel form).

Please let us know if you have any questions.

Also, to ensure CMS receipt of this request for reconsideration, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21244-1850

CENTER FOR MEDICARE

DATE: March 12, 2024

TO: Arrah Tabe-Bedward, Hearing Officer
Deputy Director, Center for Medicare and Medicaid Innovation

FROM: Elizabeth H. Goldstein, Ph.D., Director
Division of Consumer Assessment and Plan Performance

RE: CMS's Memorandum in Support of Denial of SCAN's (Contract H5425) Appeal of its 2025 Quality Bonus Payment Rating

INTRODUCTION

The Affordable Care Act of 2010 amends section 1853(o) of the Act[1] to require CMS to make quality bonus payments (QBPs)[2] to Medicare Advantage (MA) organizations that achieve at least four stars in a five-star quality rating system. The Affordable Care Act also amends section 1854(b)(1)(C) of the Act to change the share of savings that MA organizations must provide to enrollees as the beneficiary rebate, mandating that the level of rebate is tied to the level of an MA organization's QBP rating. As a result, beginning in 2012, quality/Star Ratings directly affected the monthly payment amount MA organizations receive from CMS.

On November 1, 2023, CMS announced that the 2025 QBP determinations would be based on the 2024 Star Ratings released in October 2023 on the Medicare Plan Finder tool at www.medicare.gov.

SCAN Health Plan (SCAN) requested a reconsideration of the 2024 Star Ratings and associated 2025 QBP rating for contract H5425. SCAN claims that for the Part C call center measure C30, CMS used incorrect data in the calculation of the measure. They argue that one of the foreign language interpreter availability calls (C0600900) was incorrectly scored or included in their results based on a technical issue associated with what SCAN claims was the non-standard way the CMS caller asked the standard question for their contract H5425. The reconsideration official upheld the 2024 Star Ratings and 2025 QBP determination for H5425. (Exhibits A and B)

[1] References to "the Act" are to the Social Security Act.
[2] The statute provides for an increase to the benchmark used to determine payments to MA plans (section 1853(o)) and for an increase in the percentage of the rebate an MA plan that bids below the benchmark receives (section 1854(b)(1)(C)(iii)) based on the quality rating of the plan. In 42 C.F.R. § 422.260(b), CMS defines the term "quality bonus payment (QBP)" as meaning both of these.

APPLICABLE AUTHORITY

The Act authorizes CMS to enter into contracts with entities seeking to offer MA benefits and Medicare outpatient prescription drug (Part D) benefits to their plan enrollees. [Social Security Act, § 1857 and § 1860D-12] Also, MA organizations offering coordinated care plans must offer Part D benefits in the same service area. [42 C.F.R. § 422.4(c)(1)]

The Affordable Care Act amends section 1853(o) of the Act to require the Secretary to implement a quality-based bonus payment for MA plans based on a five-star rating system beginning in 2012 (See section 1102 of the Health Care Education and Reconciliation Act (H. R. 4872)). For CY 2025 payments, plans with less than 4 stars will not receive a QBP percentage increase to the county rates, and plans with 4 or more stars will receive a QBP percentage increase to the county rates, as set forth in sections 1853(n) and 1853(o) of the Act. Under 1852(e) of the Act, MA organizations are required to collect, analyze, and report data that permit measurement of health outcomes and other indices of quality. The Star Ratings calculated for consumer choice are also used for MA QBPs.

Under 42 C.F.R. § 422.260, CMS has made an administrative review process available to MA organizations for payment determinations based on the quality bonuses. MA organizations may request an administrative review of their Star Rating for QBP determinations and rebate retention allowances.

REVIEW OF APPEAL PROCESS

Administrative Review Process for QBP Determinations

Section 422.260 provides for a two-step administrative review process that includes a request for reconsideration and a request for an informal hearing on the record after an adverse reconsideration decision. The first step allows the MA organization to request a reconsideration of how its Star Ratings for the given measure(s) in question were calculated and/or what data were included in the measure(s). If the MA organization is dissatisfied with CMS's reconsideration decision, the contract may request an informal hearing to be conducted by a hearing officer designated by CMS.

Scope of Administrative Review

Under § 422.260(c)(3)(ii), an administrative review cannot be requested for the following: the methodology for calculating the Star Ratings (including the calculation of the overall Star Ratings), cut-off points for determining measure thresholds, the set of measures included in the Star Rating system, and the methodology for determining QBP determinations for low enrollment and new plans. Therefore, requests for reconsideration and an informal hearing may be filed for QBP purposes only under a limited set of circumstances.

Permissible bases for requests for both types of reviews include a calculation error (miscalculation) or a data inaccuracy (incorrect data). A calculation error could impact the individual measure's value or the overall Star Rating. If an MA organization believes the wrong set of data was used in a measure (e.g., wrong timeframe for the data or wrong measure selected), this is considered a calculation error.

Request for Reconsideration

The reconsideration review affords an MA organization the opportunity to request review of specific measure values that may affect the calculation of the contract's QBP. The request for reconsideration must specify the given measure(s) in question and the basis for reconsideration. The alleged error could impact an individual measure's value or the overall Star Rating. The request must include the specific findings or issues with which the contract disagrees and the reason for the disagreement, and should also include specific examples of the miscalculation and/or data inaccuracy if relevant. The request for reconsideration may include additional documentary evidence that the MA organization would like CMS to consider. In conducting the reconsideration, the reconsideration official reviews the QBP determination, the evidence and findings upon which it was based, and any other written evidence submitted by the organization or by CMS. The reconsideration official's decision is final and binding unless a request for an informal hearing is filed in accordance with the instructions provided with the reconsideration official's decision.

Informal Hearing

Section 422.260 outlines the process and scope of the informal hearing. An informal hearing request may not be made unless reconsideration was first requested and the reconsideration decision has been sent to the MA organization. Section 422.260(c)(2)(iii) specifies that the informal hearing request must pertain only to the measure(s) and value(s) in question that precipitated the request for reconsideration. Requests must include a statement that describes the error(s) that the MA organization asserts CMS made in its QBP determination and how correction of those errors could result in the organization's qualification for a QBP or a higher QBP. Under § 422.260(c)(2)(v), the MA organization must provide clear and convincing evidence that CMS's calculations of the measure(s) and value(s) in question were incorrect; in other words, the burden is on the MA organization to prove an error was made in the calculation of the QBP. See also CMS's November 1, 2023 memo, 2025 Quality Bonus Payment Determinations and Administrative Review Process for Quality Bonus Payments and Rebate Retention Allowances. (Exhibit C, pages 6-7)

Decision of Hearing Officer

Per § 422.260(c)(vii), the hearing officer's decision is final and binding on both the MA organization and CMS. In the event that the hearing officer finds that the contract's QBP determination was incorrect, CMS is obligated to recalculate the organization's QBP status based on that finding.

In addition, CMS may, on its own initiative, revise an MA organization's QBP status at any time after the initial release of the QBP determinations through April 1 of each year. CMS may take this action on the basis of any credible information, including the information provided during the administrative review process that demonstrates that the initial QBP determination was incorrect. 42 CFR 422.260(d).

Possible Result of Changes to Star Ratings

If the hearing officer's decision is in favor of the MA organization, relief would be recalculation of the MA organization's QBP. Recalculation could cause the requesting MA organization's QBP to

go higher or lower. In some instances, the recalculation may not cause the Star Rating to rise above the cut off for the higher QBP rating. (Exhibit C, page 7) When the hearing officer's decision requires that a measure be systematically recalculated for all contracts, all other affected contracts (e.g., contracts of other MA organizations) will receive the recalculation if it results in a higher Star Rating, and any resulting change will be made to the Star Ratings and QBPs for all affected contracts. Other affected contracts' 2024 Star Ratings, which are used for 2025 QBPs, will not be decreased by CMS as a result of a systematic recalculation. (Exhibit C, page 7)

A change in data values for a measure may not necessarily change the Star Rating for that measure or the overall Star Rating for the contract. Since Star Ratings for a measure are based on cut points, a significant change in the data is usually required in order for a contract to move from a lower Star Rating to a higher one. Even if there is a change in the Star Rating for one or more measures, the contract's overall Star Rating may not change because the change is not significant enough to move it to the threshold for the next higher overall Star Rating.

STATEMENT OF FACTS

CMS followed the methodology codified at §§ 422.160 - 422.166 and 423.180 - 423.186 to calculate the ratings for H5425. In accordance with the instructions provided in CMS's November 1, 2023 memo and under § 422.260, SCAN filed a request for reconsideration. SCAN's request for reconsideration was based on their assertion that CMS used incorrect data in the calculation of measure C30 for contract H5425.

Following the reconsideration review, the reconsideration official upheld H5425's QBP rating. The reconsideration official found that SCAN did not provide evidence that measure C30 was miscalculated.

In accordance with the instructions provided in the February 22, 2024 reconsideration decision letter (Exhibit A) (and pursuant to § 422.260), SCAN appealed the reconsideration official's decision and requested an informal hearing on the record. (Exhibits D.1, D.2, and D.3)

STANDARD OF REVIEW

The MA organization bears the burden of proving an error was made in the calculation of its QBP rating, and it must provide a preponderance of evidence that CMS's calculation of the measure(s) and the QBP Star Rating were incorrect.

ARGUMENTS

SCAN says in its request for an informal hearing that in the reconsideration decision they requested that call C0600900 be reclassified as successful, but SCAN wants to make clear that they request that it be considered as successful or taken out of the calculation.

Currently, the score for C30 is 95% (i.e., 61 successful calls / 64 total calls), which resulted in a measure rating of 4 stars. If an additional call was successful, the score for C30 would be 97% (i.e., 62 successful calls / 64 total calls), which would be 5 stars for the measure. If CMS removed one call from the calculation of C30, the measure score would be 97% (i.e., 61 successful calls / 63 total

calls). It does not matter if CMS treats a call as successful or removes it from the measure if CMS were to update the score for C30. The score for C30 is the same under both scenarios.

The C30 measure examines the number of completed contacts with an interpreter and via TTY divided by the number of attempted contacts.[3] To determine compliance with these requirements, CMS places outbound calls to plans' call centers and during these calls CMS's contracted surveyor starts and stops timers to record hold times, time for customer service representatives (CSRs) to respond to questions, and time to bring interpreters into the call. Completed contact with an interpreter is when the CSR, via an interpreter, provides an affirmative response to the introductory question (e.g., "Are you the right person to answer questions about [Plan name's] health benefits?") within eight minutes (see Exhibit E, p. 84).

SCAN argues that CMS ignored the manner in which the question was asked for call C0600900 and has improperly treated call C0600900 as an unsuccessful call. SCAN contends that line 4 of the table on pages 5 to 6 in the Technical Report (Exhibit B) does not capture the manner in which the question was delivered, including restarting the question and many long pauses which they assert caused confusion for the interpreter and resulted in the need to repeat the question. SCAN provides the following to show this:

> *French: Bonjour. "Êtes-vous la per…..…..Êtes-vous la personne adéquate pour répondre aux questions concernant les avantages médicaux…..de…uh….Village Health….. H-M-O……P-O-S…. C…..S-N-P?"*

SCAN argues that "Without that secret shopper's delay caused by the non-standard manner in which the question was asked, the call would have been completed within the 8-minute time limit, even with the amount of time it took to get the interpreter on the line."

The English translation of the above is: "Hello. Are you the…are you the right person to answer questions about health benefits of Village Health HMO-POS C-SNP?" There are pauses as the caller reads the 10 letter acronym portion of the plan name.

Although SCAN states that the interpreter was confused based on this transcript, there is no statement from the interpreter independent of what is heard from the interpreter on the recording; on the recording, the interpreter can be heard stating in French: "Excuse me, ma'am. I missed that." a SCAN argues this means that the interpreter was confused but has provided no actual evidence that the individual was confused. CMS's transcript was provided by Hendall Inc., the contractor for the call center study (Exhibit F). That transcript has the interpreter saying "Excusez, madame, j'ai…j'ai raté de prendre notes. Les avantages médicaux de Village, s'il vous plaît, si vous pourrez répéter?" Translated into English, this means "Excuse me, ma'am, I…I failed to take notes. Health benefits of Village, if you will repeat please?" "J'ai raté de prendre notes" can also mean "I missed taking notes". Even if SCAN's translation is most accurate, and even assuming the interpreter was confused, there is no evidence to suggest that the confusion is caused by the caller's delivery.

[3] "Completed contacts" for purposes of the C30 measure is established as follows: (1) Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within eight minutes; and (2) Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within seven minutes. Medicare 2024 Part C & D Star Ratings Technical Notes (available online at 2024technotes20230929.pdf (cms.gov)) or Exhibit E, page 84.

With respect to delivery, CMS's publicly stated goal in this study is to replicate the experience of beneficiaries,[4] and the fact that callers do not announce themselves as calling on behalf of CMS further shows that they are standing in place of beneficiaries. Like beneficiaries, the cadence and mannerisms of CMS callers are not always the same. While CMS callers undergo an extensive training and certification process that includes communicating health and drug insurance terms, they are not expected to be universal in delivery, which means there may be variations in pauses when asking questions. In fact, CMS would rather have its test callers be more deliberate and spell things out when they see fit as opposed to rushing through a question and misspeaking. Each beneficiary that calls a health plan's call center will not have the exact same delivery in terms of how they ask a question, including pronunciation and pauses. The issue here is not the caller but rather the amount of time needed for SCAN to conference in an interpreter and for the interpreter to communicate back to the caller that the plan representative was able to answer questions about plan benefits. Further, having CMS's test callers either announce themselves or use an identical delivery would undermine the purpose of the survey and the call center measure, by providing MA organizations (and Part D sponsors) the ability to identify the test calls and provide better performance on those calls than when actually engaging with beneficiaries. The test calls are not designed to be presented in a vacuum under conditions that are most perfect or beneficial for the MA organization or Part D sponsor. The call center study and the Star Rating measure are intended to provide a picture of how the plan ensures that current and prospective Medicare beneficiaries who need translation services have access to a CSR capable of answering questions about the plan.

SCAN argues that in their Request for Reconsideration, they "included a recording of another French call (C1201277…) where the exact same question was asked with the same plan name, and the CMS caller did ask the question in a conversational way without long pauses. The question was asked in 17 seconds (32% less time) and the plan name was very clear, and the interpreter had no issue understanding the question and did not need to ask for it to be repeated." SCAN further argues that the reconsideration decision did not provide a non-arbitrary rationale for why call C0600900 was treated differently than call C1201277. SCAN also states, "…CMS has taken the position elsewhere that it would not penalize Medicare Advantage plans for delays and confusion introduced even by interpreters in answering questions, as CMS 'wouldn't hold that against you' and would not 'count against you.' 2016 CMS Call Center Monitoring Q&A at 3, https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting."

First, SCAN is incorrect that CMS's position is arbitrary. As explained above, the test calls are not identical because they are a way to mimic real-life, real-world calls to the plan's call center to evaluate the plan's actual performance in connecting callers with limited English proficiency with responsive customer service. Using an artificially uniform and identical approach for how the questions are answered undermines the purpose of the study. SCAN's position, in essence, is that its plan performance should only be evaluated by CMS for the Star Ratings measure using uniform delivery by the test caller such that SCAN's services are only evaluated by perfectly presented questions; such an approach fails to truly evaluate how Medicare beneficiaries who need interpretation services would access SCAN's customer service center. An important and relevant

[4] See December 1, 2022 HPMS memo titled *2023 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies*, page 7, second to last bullet (Exhibit J, Appendix A); Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes pages 19, fourth paragraph from the bottom (discussing TTY calls, also part of the study), and 28, second paragraph (Exhibit J, Appendix C); 2016 webinar page 63, (Exhibit G).

distinction between calls C1201277 and C0600900 is the amount of time to conference in an interpreter (i.e., less than 2 minutes and 30 seconds for C1201277 and 6 minutes and 35 seconds for C0600900) and confirm that the plan representative would be able to answer questions about the plan's benefits. CMS counted C0600900 as unsuccessful based on SCAN not meeting the eight-minute requirement[5] for providing an interpreter based on the metric definition provided in the 2023 Part C and Part D Call Center Monitoring – Timeliness and Accuracy & Accessibility Studies Health Plan Management System (HPMS) memo released on December 1, 2022, the Medicare Part C & D Call Center Monitoring Technical Notes (Exhibit B, Appendix C, p. 6), and the 2024 Part C and D Star Ratings Technical Notes (Exhibit E, p. 84).

Second, SCAN either misread or misrepresents the 2016 CMS Call Center Monitoring Q&A when it says CMS has not been consistent in counting calls as either successful or unsuccessful even when interpreters cause delay or confusion. The question referenced by SCAN was specifically about the accuracy of answers to questions about a plan's benefits. CMS conducts tests to measure the accuracy of plan information provided by CSRs in all languages; the accuracy test is not part of the Part C and D Star Ratings call center measures. This accuracy test occurs after CMS has determined that an interpreter is available. At that point, the caller will ask up to three questions about the plan's benefits. This Q&A cited by SCAN is irrelevant to the issue at hand since the accuracy test is not part of the Star Ratings call center measures. Below is the question, the answer provided during the webinar, and the clarification provided in the very document cited by SCAN (Exhibit G, FAQs document).[6]

> ***Question:*** *Is the accuracy test on the actual answer provided by the plan's CSR or on the quality of the interpreter to relay the answer in the foreign language?*
>
> *Webinar Answer: Our goal is not to test language translation's ability to translate language. That is a different test. Our hope and dream is that you are able to provide answers to them [callers]. If it is obvious that the interpreter on the line is not successfully interpreting – which means, I think, a native speaker often knows when something doesn't make sense in their language -- I don't think that we would count against you. I don't know if it gets documented, so I would have to look to Chris for that answer.*
>
> *[Chris] Well, I would say too that the questions we are asking are more plan-specific questions so the real emphasis is that customer service representative be able to answer plan-specific questions, and that might be something on your formulary [for example]. It should be pretty straightforward. I wouldn't anticipate too many problems, but if you experience that and you need to come to us to say we don't think this is fair the way this was counted, reach out to me. We do have mechanisms where if you have the recorded conversation we can listen to it to see if there is a problem and check our own finish notes from our contractor's records and make a judgment*

[5] The eight-minute requirement begins when a live person answers the phone, as opposed to time spent in an interactive voice response (IVR) when a recording is playing.

[6] Please note that on page 5 of the webinar presentation, it states, "*Nothing in this presentation is intended to supersede the regulations at 42 C.F.R. Part 422, 42 C.F.R. Part 423, the Prescription Drug Benefit Manual, the Medicare Managed Care Manual, or any other CMS guidance or instructions related to the operation of the MA program or Part D program. Failure to reference a regulatory requirement or CMS instruction in this presentation does not affect the applicability of such requirement.*"

call on that. If it is due to the failure strictly of the interpreter, I wouldn't hold that against you.

Clarified Answer: *One of the goals of the Accuracy & Accessibility Study, which is performed by testing interpreter availability, TTY functionality, and accuracy of the questions asked, is to determine if interpreters are available and to determine the accuracy of responses given to prospective members. So, we would separate the interpreter availability component from this question, as it is a given that an interpreter is available in this scenario. In regard to the accuracy questions, an interpreter must be able to respond to questions accurately, so if the interpreter did not do that correctly, this must be attributed to the plan's performance. If the response to the question is not relayed correctly due to the failure of the language interpreter with whom the plan contracted, we believe it is everyone's best interest to report that negative result back to the plan through the failure of the accuracy question being tested. Doing so helps inform the interpretation service's performance, and the plan can use that feedback for its future business decisions. In this scenario, we do not score or judge the interpreter's performance throughout the call – we are only looking for the correct response to the question. We would not hold the performance of the interpreter against the plan, generally speaking, so long as the response to the accuracy question is accurate. We are always happy to hear from any plan who believes a certain result may be unfair, and we are certainly willing to investigate issues that may arise, but in this instance described above, failure to respond accurately due to the failure of the interpreter is counted against the plan in the form of incorrect response to that the question being tested.*

SCAN's argument suggests that the underlying important distinction between these two calls is the 8 second difference in the caller's initial question between call C0600900 (25 seconds) and call C1201277 (17 seconds) – in effect that CMS should not permit test callers to take longer than 17 seconds to ask if the CSR can answer questions about an HMO POS C-SNP (that is, a Health Maintenance Organization Point of Service Chronic Condition Special Needs Plan). SCAN states that without the test caller's "delay," the call would have been completed within the 8-minute time limit even with how long it took for SCAN to locate an interpreter. SCAN argues that they understand it took 6 minutes and 35 seconds to get an interpreter on the line for the call in question, but they assert that all that is relevant for the informal hearing officer is whether 1 minute and 25 seconds is enough time for the CMS caller to complete their question and get a response from the CSR. They state that the failed call, C0600900, took 86 seconds to confirm that the plan representative would be able to answer questions about plan benefits relative to 41 seconds for a successful call that they reference in their appeal. They argue that this is not "… a normal variation in a conversational way of asking the standard question." On page 3 of its request for an informal hearing, SCAN basically argues that SCAN should only be evaluated based on the time period that elapses between when the interpreter comes on the line and when the CSR responds that they can answer the caller's questions when SCAN frames the issue as whether the informal hearing officer thinks 1 minute and 25 seconds is enough time to complete the cycle of the CMS caller asking the introductory question and getting the response from the CSR. That argument misconstrues the purpose of the call center study and removes from consideration how long a caller must wait on hold for an interpreter and how well the interpreter listens and translates the caller's question and the CSR's response. SCAN also argues that if the question from the caller had been asked more quickly and without pauses, the call would have been marked as successful; however, had the interpreter not requested that the question be repeated – apparently because the interpreter did not

take notes or did not understand that SCAN's plan name included an acronym that is 10 letters long – the call could potentially have been completed successfully within the 8 minute period as well. CMS disagrees that there was anything irregular or inappropriate about how CMS's test caller conducted call C0600900. In summary, all of SCAN's arguments are essentially attempts to shift the focus from the 6 minute and 35 second delay to bring an interpreter on the line, a delay for which SCAN was entirely responsible. Successful performance on this measure is about efficiently getting an interpreter on the line and the interpreter efficiently and accurately translating the introductory question from the caller and the response from the customer service representative so that the caller is able to ask substantive questions about the plan.

SCAN argues that the information CMS provided in the Technical Report (Exhibit B) about the number of French calls placed to all plans, information about how the same question is asked on all calls, and C0600900 being the only French language call questioned in this year's study is irrelevant. They further state that they are not contending that CMS asks different question across the calls, but they are contending that the way the question was asked on C0600900 was non-standard resulting in the call going over the time limit.

CMS disagrees with the assertion that the number of calls is irrelevant and that the question was asked in a non-standard manner. CMS noted the number of calls and the fact that this is the only French call questioned in response to SCAN's argument that the caller framed the question in a different way than what is identified in the Medicare Part C & D Call Center Monitoring Technical Notes. Per SCAN, the caller asked (in French), "are you the right person to answer questions about the medical advantages of Village Health HMO-POS C-SNP." They argued, in the "Additional Comments" in their request for reconsideration (Exhibit H), that when dealing with MA products, asking the question with "medical advantages" right before the plan name can cause additional confusion for the interpreter. CMS responded to this at the reconsideration level by showing that (1) the standard question, asked in French, was appropriate, (2) the caller did not deviate from the standard question, and (3) if the standard question was being asked incorrectly during French calls, causing confusion, monitored organizations and/or their interpreter service providers would likely have communicated the issue to CMS this year or in prior years when the same translation was used.

SCAN further argues that the Technical Report (Exhibit B) states at page 2 that measure C30 is used to "ensure compliance with regulatory requirements, found at 42 C.F.R. §§ 422.111(h)." SCAN notes the regulation states, "interpreters must be available for 80 percent of incoming calls requiring an interpreter within 8 minutes of reaching the customer service representative." SCAN cites the Meriam-Webster Dictionary definition of available and United States v. Soybel, 13 F.4th 584, 595 (7th Cir. 2021), and argues that "available" means "present or ready for immediate use". SCAN goes on to argue that because the caller was connected to the interpreter at 6 minutes and 35 seconds that this call met the standard due to having an interpreter "available" within 8 minutes. SCAN argues that there is "an arbitrary misalignment" with the goal that CMS outlines in the regulation for interpreter availability and the reconsideration decision that required the answering of a caller's questions within 8 minutes.

SCAN is either mistaken in understanding the purpose of the Star Rating quality measures and how quality ratings are not compliance actions (e.g., a notice of non-compliance, a warning letter or a

corrective action plan)[7] or misconstruing the scope of this appeal. In the Technical Report (Exhibit B) as part of the background section, we note that "CMS monitors plan sponsors' Part C and Part D call centers to ensure compliance with regulatory requirements, found at 42 C.F.R. §§ 422.111(h) and 423.128(d), for providing timely and accurate information." Even if SCAN is correct in how the cited regulations should be interpreted (which CMS does not concede), the issue here is how SCAN scored on the Star Rating quality measure. SCAN is mischaracterizing the measure specifications for the Star Ratings call center measures. The measure specification for the Part C and D Star Ratings has included, "Successfully completed contact with an interpreter is defined as establishing contact with an interpreter *and answering the introductory question* (before beginning the first of three general or plan-specific accuracy questions) within eight minutes" since the 2018 Star Ratings (Exhibit J, page 5 shows the 8 minute requirement for the study administered in 2017; there have been no changes since then in the 8 minute requirement) (emphasis added). In annual memos, including the December 1, 2022 memo announcing the 2023 monitoring[8], CMS defines interpreter availability: "Interpreter availability is defined as the ability of a caller to communicate with someone and receive answers to questions in the caller's language. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits…" While we also believe this is the correct interpretation for the level of performance required by §§ 422.111(h) and 423.128(d), the specific phrasing of those regulations is not relevant here. The Star Rating measure specifications are clear and were applied correctly here. In both the February 2020 proposed rule (85 FR 9116) and the January 2021 final rule (86 FR 6006, 6007, and 6008), we made clear that the regulation would be interpreted and applied consistent with our longstanding monitoring and oversight activities (meaning the annual call center study).

The Medicare Part C & D Call Center Monitoring Technical Notes, available to SCAN with the call center monitoring results in HPMS, state that the limited English proficiency (LEP) hold time "…is a code used to capture the time waiting for the interpreter. Each call is allotted eight minutes for this timer. LEP Hold time begins after reaching a live customer service representative and ends after the interviewer has confirmed that the CSR is available and able to assist in answering questions about Medicare Part C or Part D benefits." The 2024 Part C & D Star Ratings Technical Notes C30 metric reinforces the definition, providing that "[t]he calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within eight minutes…" The Medicare Part C & D Call Center Monitoring Technical Notes back to the study done in 2017 for the 2018 Star Ratings included the eight minute requirement. Specifically, it states that "A call is considered **successful** when the caller confirms that the CSR is able to assist in that language. A call is considered **complete** when establishing contact with an interpreter and beginning the first of three survey questions within eight minutes of reaching a CSR." (Exhibit J, page 5)

In summary, CMS believes that the caller acted appropriately, the question asked was accurate, and the resulting determination that the plan exceeded the eight-minute threshold to confirm that the plan can answer questions about the plan benefits is correct. CMS followed the established Star Ratings methodology to calculate SCAN's 2024 Star Rating for C30 and the overall rating.

---

[7] 42 CFR § 422.504(m) lists the types of compliance actions CMS may take in response to noncompliance; in addition, there are intermediate sanctions available as described in 42 CFR §§ 422.750 through 422.764.

[8] 2023 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies HPMS memo

RECOMMENDED FINDINGS AND CONCLUSION

CMS has the authority to enter into a contract with MA organization SCAN. CMS has specified standard measures and uniform data collection and reporting instruments. In order to ensure fairness and consistency among all contracts, CMS uses the same protocol, parameters, and analysis methods for each contract. The burden is on the MA organization to prove an error was made in the calculation of its ratings. As such, SCAN has failed to provide evidence that CMS's calculation of C30 and its 2024 Star Ratings is incorrect for H5425, or that its 2025 QBP rating is incorrect.

Respectfully Submitted,

/s/

Elizabeth H. Goldstein, Ph.D.

LIST OF EXHIBITS

Exhibit A – QBP Decision Letter SCAN Health Plan H5425

Exhibit B – Technical Report for H5425 and Appendices

Exhibit C – 2025 Quality Bonus Payment Determinations and Administrative Review Process for Quality Bonus Payments and Rebate Retention Allowances, CMS memo dated November 1, 2023

Exhibit D.1 – H5425's Request for Informal Hearing Form

Exhibit D.2 – H5425's Summary of Informal Hearing Request

Exhibit D.3 – H5425's Exhibits

Exhibit E – Medicare 2024 Part C & D Star Ratings Technical Notes

Exhibit F – CMS Transcript of French Call C0600900

Exhibit G – FAQs and Webinar

Exhibit H – Request for Reconsideration Form from SCAN

Exhibit I – 2017 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies, CMS memo dated November 16, 2016

Exhibit J – Medicare Part C&D Call Center Monitoring Accuracy and Accessibility Technical Notes, Revision Date 6/1/2017

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21244-1850

CENTER FOR MEDICARE

February 22, 2024

Reconsideration Determination for H5425

Dear Mr. Plumb,

SCAN Health Plan's contract H5425 requested an administrative reconsideration of its 2025 Quality Bonus Payment (QBP) determination. The request was based on the 2024 Star Ratings for the measure: Call Center – Foreign Language Interpreter and TTY Availability (C30). I reviewed the QBP determination, the evidence and findings upon which the initial determination was based, and the additional information your organization submitted. As a result of my review, CMS will not change the QBP rating for H5425. **This reconsideration decision is final and binding unless a request for an informal hearing is filed in accordance with the instructions provided in this reconsideration decision notice.**

The reason for my decision is outlined in Attachment A, "Technical Report for SCAN Health Plan H5425." Attachment A explains how the measure and values in question were calculated and provides specific information about this contract's data. The methodology for the Medicare Advantage (MA) and Part D Star Ratings is codified at §§ 422.160 - 422.166 and 423.180 - 423.186. The Medicare 2024 Part C & D Star Ratings Technical Notes, located at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html, also contain details about the methodology. Please note that, under our regulations and as discussed in Attachment A, "[a]n administrative review cannot be requested for . . . the methodology for calculating the star ratings (including the calculation of the overall star ratings)" or "the set of measures included in the star rating system." 42 CFR 422.260(c)(3)(ii). The information in Attachment A may help your organization determine whether requesting an informal hearing would be beneficial.

The administrative review process is a two-step process that includes a request for reconsideration and a request for an informal hearing on the record. This notice of the contract's reconsideration determination concludes the first step of the administrative review process. If your organization is dissatisfied with this reconsideration decision, the contract may request an informal hearing on the record to be conducted by a hearing officer designated by CMS.

The informal hearing request must pertain only to the measure and values in question that precipitated the request for reconsideration, in this case the measure: Call Center – Foreign Language Interpreter and TTY Availability (C30). The request must include a statement that describes the error(s) the contract asserts CMS made in its QBP determination and how correction of those errors could result in the organization's qualification for a higher QBP. In making the request your organization must provide clear and convincing evidence that this

reconsideration determination is incorrect. The burden is on the MA organization to prove an error was made in the calculation of its QBP. The hearing officer's decision will be final and binding on both the MA organization and CMS.

In the event that the hearing officer finds that your organization's QBP determination was incorrect, CMS will be obligated to recalculate the organization's QBP status based on that finding. The recalculation could cause your organization's QBP to become higher *or lower*. In some instances, the recalculation of the measures may not cause the Star Rating to rise above the cut off for the higher QBP Star Rating.

Pursuant to the MA organization's agreement with CMS, the deadline for providing written notice requesting an informal hearing under 42 C.F.R. § 422.260(c)(2) is five business days from the issuance of this reconsideration decision, not ten days. Request for an informal hearing on the record regarding the 2025 QBP determination is made by completing Attachment B, "Request for an Informal Hearing," and e-mailing the completed form and supporting documentation to QBPAPPEALS@cms.hhs.gov by **5:00 p.m. EST on February 29, 2024. A request for an informal hearing must be submitted by the date and time above or this reconsideration decision is final and binding.** Please ensure you receive confirmation from the mailbox that your request was received.

Any questions regarding this decision may be submitted to QBPAPPEALS@cms.hhs.gov.

Sincerely,

Jeff Grant, CMS Reconsideration Official
Deputy Director for Operations
Center for Consumer Information and Insurance Oversight

Attachment A: Technical Report for SCAN Health Plan H5425
Attachment B: Request for an Informal Hearing

Technical Report for SCAN Health Plan H5425

Contents

Factual Background **2**

Regulations Governing the 2024 Part C and D Star Ratings 2

Call Center Monitoring 2

Contract's Description of the Issue: Call Center - Foreign Language Interpreter and TTY Availability (C30) **3**

CMS's Response: Call Center - Foreign Language Interpreter and TTY Availability (C30) **5**

Conclusion **7**

Appendices **8**

Factual Background

Regulations Governing the 2024 Part C and D Star Ratings

The Centers for Medicare & Medicaid Services (CMS) develops and publicly posts a 5-star rating system for Medicare Advantage (MA)/Part C and Part D plans as part of its responsibility to disseminate comparative information, including information about quality, to beneficiaries under sections 1851(d) and 1860D–1(c) of the Act and based on the collection of different types of quality data under section 1852(e) of the Act. The Part C and Part D Star Ratings system is used to determine quality bonus payment (QBP) ratings for MA plans under section 1853(o) of the Act and the amount of MA beneficiary rebates under section 1854(b) of the Act. The methodology for the Star Ratings system for the MA and Part D programs is codified at §§ 422.160 through 422.166 and 423.180 through 423.186, respectively, and we have specified the measures used in setting Star Ratings through rulemaking.

Call Center Monitoring

CMS monitors plan sponsors' Part C and Part D call centers to ensure compliance with regulatory requirements, found at 42 C.F.R. §§ 422.111(h) and 423.128(d), for providing timely and accurate information. The purpose is to measure plans' call center accessibility for current members and prospective members and to determine if the information provided to prospective members is accurate. Performance for the Part C and Part D call center measures is based on the Part C & D Call Center Monitoring Accuracy and Accessibility Study conducted from approximately February through June 2023. CMS provided notice to MA organizations and Part D sponsors, via an HPMS memo dated December 1, 2022 ("2023 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies") (see Appendix A), that the study would be conducted. In conducting the study, the CMS contractor only uses the call center phone numbers (including TTY numbers) identified by the plan in HPMS for contacting the call center.

There are two call center measures included in the Part C and D Star Ratings program – one measure focuses on Part C and the other on Part D. The measures capture Teletypewriter (TTY) Functionality[1] and Accessibility of Foreign Language Interpretation[2] when prospective members call the health and drug plan, respectively. Defined in a December 1, 2022, Health Plan Management System (HPMS) memo titled "2023 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies" (see Appendix A), and in the Medicare 2024 Part C and D Star Ratings Technical Notes[3], these measures examine the number of completed contacts with an interpreter and via TTY divided by the number of attempted contacts. To determine compliance with these requirements, CMS places outbound calls to plans' call centers.

During these calls, CMS's contracted surveyor starts and stops timers to record hold times, time for customer service representatives (CSRs) to respond to questions, and time to bring

[1] 42 C.F.R. §§ 422.111(h(1)(iv) and 423.128(d)(1)(v)
[2] 42 C.F.R. §§ 422.111(h)(1)(iii) and 423.128(d)(1)(iii)
[3] https://www.cms.gov/files/document/2024technotes20230929.pdf

interpreters into the call. Completed contact with an interpreter is when the CSR, via an interpreter, provides an affirmative response to the introductory question (e.g., "Are you the right person to answer questions about [Plan name's] health benefits?") within eight minutes, before being asked the three accuracy questions. Interpreters must be able to communicate responses in the non-primary language used by the call surveyor. Completed contact with a TTY service is when the call surveyor can connect to a live CSR and the CSR answers "yes" to the introductory question within seven minutes, before being asked three accuracy measure questions. There must be communication received back from the CSR or TTY relay operator in order to confirm that the TTY device is working properly, and a connection is made so that all parties can communicate.

The surveyor reports that a call is an "unsuccessful call" as defined by the survey methodology when the call terminates early or fails to connect without action by the surveyor or error on the surveyor end. Such calls are counted as unsuccessful calls when the plan's survey results are tabulated. On the other hand, if the call disconnects because of the surveyor's action, surveyor's error, or other failure on the surveyor's end, the surveyor does not report the call as an "unsuccessful call" and the call is not counted in the plan's survey results at all.

Contract's Description of the Issue: Call Center - Foreign Language Interpreter and TTY Availability (C30)

SCAN Health Plan (SCAN) claims that for the Part C call center measure C30, CMS used incorrect data in the calculation of the measure. They argue that one of the foreign language interpreter availability calls (C0600900) was incorrectly included in their results based on a technical issue associated with the non-standard way the CMS caller asked the standard question for their contract H5425.

SCAN states that for call C0600900, received on 2/9/2023, there was a technical issue caused by the CMS caller's deviation from protocol that caused the call to exceed the 8-minute threshold. They argue the CMS caller did not ask the question clearly, including a stumble at the start, and spoke unusually slowly and stated the plan name in a non-standard manner that the interpreter had trouble understanding. This included several pauses during the question that increased the time it took to ask the question. The total time taken to ask the question was 25 seconds, which they believe demonstrates how long the pauses were. SCAN states that the CMS caller's phrasing of the question and the way it was asked, specifically the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. They state it was the additional 34 second delay caused by the question needing to be repeated that ultimately caused the call to exceed the 8-minute threshold.

For comparison purposes, SCAN references call C1201277 which was received on 3/24/2023. SCAN states that in call C1201277, the CMS caller asked the same question more clearly without the stumbling and excessively slow spelling out of the plan name (which was the exact

same plan name as in call C0600900). The total time taken to ask the question in call C1201277 was just 17 seconds and did not result in the interpreter needing to have the question repeated to translate. The total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 41 seconds.

SCAN states that for call C0600900, the total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 86 seconds – 45 seconds longer than in call C1201277 where the caller did not stumble through the question and was much clearer. The failed call missed the time cutoff by 31 seconds. Thus, they argue were it not for the additional delay caused by the non-standard way the CMS caller asked the question in C0600900, that call would have passed and been counted as a successful call. Additionally, they state in spite of the 25 seconds it took just to ask the standard question in call C0600900, if you exclude the additional time associated with the question having to be repeated (34 seconds), the call would have been completed within the time limit.

SCAN states that time delays that are caused by the CMS caller asking the question in a non-standard way, and thus causing confusion on the part of the interpreter and the need for the question to be repeated, should not be included in the evaluation of a specific call's success. Thus, they state that this call was incorrectly included as a failure in their performance data and should be counted as a completed call since the time in excess of 8 minutes was due to the CMS's caller's failure to follow established CMS protocols. At a minimum, they argue the non-standard way the question was asked should warrant exclusion of this call from the dataset for this measure. They claim that CMS mischaracterized the call as a failure, and this data inaccuracy led to a calculation error for their performance on the C30 measure.

SCAN also states that another possible contributor to the problem with call C0600900 was a technical issue with the standard question asked – specifically, that the question asked was not consistent with the standard question outlined in the Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes. They note that page 17 of the technical notes state that the introductory question asked by CMS callers is "are you the right person to answer questions about [Plan name's] health benefits?" However, in call C0600900, the CMS caller framed the question in a way different than what is identified in the technical notes. Per SCAN, the caller asked, "are you the right person to answer questions about the medical advantages of [Plan name]." They argue when dealing with MA products, asking the question with "medical advantages" right before the Plan name can cause additional confusion for the interpreter, and was a proximate cause of call C0600900 exceeding the 8-minute time limit. SCAN states where a deviation from the published CMS protocols by CMS or its contractor is the cause of an MA plan exceeding the 8-minute threshold, it is not appropriate for CMS to penalize the MA plan.

In summary, SCAN requests that call C0600900 be reclassified as a successful call in their results. This would adjust their score for measure C30 from 95% (4 stars) to 97% (5 stars).

CMS's Response: Call Center - Foreign Language Interpreter and TTY Availability (C30)

CMS disagrees with SCAN's argument that their rating for measure C30 is incorrect. CMS has utilized a contractor to place calls to MA organizations and Part D sponsor's customer service call centers since 2009. While the methodology has undergone minor changes over the years, successful calls have always been premised on reaching a live CSR who confirms they can answer questions about the plan's Medicare benefits within a specified period of time. This is true whether the caller speaks English as a first language, is using a TTY device, or speaks a language other than English. Prior to each calendar year's monitoring, CMS releases an annual HPMS memo (see Appendix A) that describes the call center monitoring studies for the coming year; provides instructions to ensure that current, prospective, and TTY customer service call center toll-free telephone numbers are entered in the appropriate locations in HPMS; and offers best practices.

Before CMS launched the 2023 study, it first reached out to plans via the annual Call Center Monitoring HPMS memo released on December 1, 2022. Within this memo CMS provided several key points of information, including the definition of interpreter availability. The memo notes, "Interpreter availability is defined as the ability of a caller to communicate with someone and receive answers to questions in the caller's language. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits (the primary language is Spanish in Puerto Rico and English elsewhere.) A *call* is considered connected when the caller reaches a CSR. The *measure* is considered *completed* when the caller confirms that the CSR is able to answer questions about plan benefits via an interpreter (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes... The percent of completed foreign language calls (number of completed foreign language calls divided by all foreign language calls) is used for star ratings measures."[4]

SCAN has argued that the result of call C0600900 (see Appendix B for raw data related to this call) was impacted due to how the CMS caller asked the question. They claim that a technical issue occurred due to the CMS caller deviating from the standard protocol. CMS asks the same question for each call and that question is "Are you the right person to answer questions about [Plan name's] health (or prescription drug) benefits?" (see Appendix C, page 17). SCAN believes that this question was asked in a non-standard way, which caused confusion for the translator. CMS disagrees with the assertion that the caller deviated from the standard protocol and provides the table below to show exactly what was said during the call.

1	Standard version of the question when asked in English	Are you the right person to answer questions about [Plan name's] health benefits?

[4] Appendix A, page 2.

2	Standard version of the question when asked in French	Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de [Plan name]?
3	Standard version of the question translated from French back to English	Are you the right person to answer questions about health benefits of [Plan name]?
4	Exactly what the interviewer actually asked in French	Bonjour. Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de Village Health HMO POS D-SNP?
5	Exactly what the interviewer actually asked translated to English	Hello. Are you the right person to answer questions about health benefits of Village Health HMO POS D-SNP?
6	What SCAN claims the interviewer asked in French	Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de [Plan name]?
7	What SCAN claims the interviewer asked translated to English	Are you the right person to answer questions about the medical advantages of [Plan name]?

SCAN cites that it took 25 seconds for the CMS caller to ask the introductory question, which they believe shows how long the pauses were when combined with the spelling out of the plan name. SCAN believes that this was an unfairly long amount of time and that this is the reason for the call failing. The CMS callers are trained to ask the question in a conversational way, as we are assessing to see if any caller at a given point in time can receive assistance. In this instance the CMS caller asked the standard question and provided the needed information the first time. Each person has a unique style of communication and to expect that each person will speak in the exact same way is not realistic. This applies to both the CMS callers and an individual Medicare beneficiary from the general public who is calling. The purpose of these test calls is to replicate the experience prospective members would have if they called the plan's toll-free number. How prospective members ask a question will differ from call to call. SCAN has suggested that 25 seconds to ask the general question is too long, but CMS believes it is within an acceptable time frame for a conversation. (Further, 25 seconds is less than 1/16th of the available time of 8 minutes for SCAN to complete the call by providing a "yes" response to the introductory question via the interpreter.)

SCAN has stated that due to the interpreter needing the question to be restated, it added an unnecessary 34 seconds to the call, which is why it failed the 8-minute timer. SCAN's

argument ignores the fact that it took over six and a half minutes for the interpreter to join the call to begin with. SCAN chose their interpreter service and, therefore, is responsible for the performance of the interpreter service they have chosen. Had SCAN gotten an interpreter on the line only 34 seconds earlier (that is, in just under 6 minutes or *75% of the available time* to complete the call successfully on the measure), the call could have been completed successfully.

SCAN also brought up an additional French language call that they received where it took 17 seconds instead of 25 to ask the introductory question. For call C0600900 (the call being appealed) SCAN says that the time to get a translated response back was 86 seconds, or 45 seconds longer than the time it took for a different call C1201277, which SCAN characterizes as having no issue with the introductory question. CMS asked the same question on both calls, and any differences in the way they were stated is down to the individual caller, just like a non-test call would be, which is what CMS is testing (that is, how quickly a Medicare beneficiary can connect with a customer service representative to get information about the plan). With this argument, SCAN again has ignored the prolonged period that it took for the interpreter to join the call. SCAN's focus on the final seconds on a call disregards how the SCAN call center wasted the first six and a half minutes waiting for an interpreter. How SCAN elects to provide interpreters is within SCAN's control and SCAN is thus responsible for how well its chosen approach works.

SCAN has argued that a time delay caused by the CMS caller asking the introductory question in a non-standard way should not be held against the plan. CMS asks the same question on all calls. We use the same translation for each foreign language call that is placed. For the 2023 study, CMS placed 1,984 calls in French. Of those 1,761 were successful, meaning the interpreter was able to interpret a "yes" response back to the CMS caller within 8 minutes. That means that 88.76% of all French language calls were successful. Call C0600900 is the only French language call that has been questioned for this year's study around the issue of how the introductory question was asked. In addition, it should be noted that SCAN was called 13 times between Part C and Part D in French for the study, and they were successful on 11 of those calls. The only other French language call that was unsuccessful was disconnected by the plan.

Finally, SCAN stated that the translation itself could be a reason for the issue that occurred. CMS has not changed the French translation of this question for several years and there have not been other issues raised around the translation.

Conclusion

Permissible bases for requests for QBP reviews include a calculation error (miscalculation) or a data inaccuracy (incorrect data), not methodology codified in regulation. The regulation at 42 CFR § 422.260(c)(3)(ii) is clear on this. CMS consistently and appropriately administered the call center study, and calls were properly placed and scored accordingly. CMS finds no evidence that we incorrectly scored the questioned call for H5425; thus, the score for measure

C30 should not be adjusted. H5425's Star Rating for measure C30 and its QBP rating will remain unchanged.

Appendices

Appendix A – 2023 Part C and Part D Call Center Monitoring.pdf
Appendix B – Case C0600900 Raw Data.xlsx
Appendix C – Call Center Monitoring Accuracy and Accessibility Study Technical Notes 508 Technical Notes_2023_06.08.23_Final.pdf

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: December 1, 2022

TO: All Medicare Advantage Organizations (MAOs), Prescription Drug Plan Sponsors and Medicare-Medicaid Plans (MMPs) (excluding PACE contracts, cost contracts, MSA contracts, and employer-only plans)

FROM: Amy Larrick Chavez-Valdez, Director
Medicare Drug Benefit and C & D Data Group

SUBJECT: 2023 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies

The Centers for Medicare & Medicaid Services (CMS) will continue monitoring Part C and Part D call centers in 2023. This memo describes the elements CMS will monitor and explains how to prepare for the monitoring studies, including updating the Health Plan Management System (HPMS) with critical 2023 call center information **no later than December 16, 2022**.

For 2023, CMS has contracted with Insight Policy Research, and its subcontractor American Institutes for Research (AIR), to monitor the performance of plan sponsors' call centers with respect to the standards at 42 C.F.R. § 422.111(h)(1) and 42 C.F.R. § 423.128(d)(1).

The **Timeliness Study** measures Part C and Part D *current enrollee* call center telephone lines and pharmacy technical help desk telephone lines to determine **average hold times** and **disconnect rates**. This study is conducted over four consecutive weeks each quarter, during which an organization is expected to maintain an average hold time of 2 minutes or less and maintain an average disconnect rate of 5 percent or less.

Important definitions for the Timeliness Study:

1. The percentage of calls disconnected is defined as the number of calls unexpectedly dropped by the plan divided by the total number of calls made to the telephone number associated with the contract.

2. The average hold time is defined as the average time spent on hold by the caller following the interactive voice response (IVR) system, touch-tone response system, or recorded greeting and before reaching a live person.

The **Accuracy & Accessibility Study** measures Part C and Part D *prospective beneficiary* call center telephone lines to determine (1) the **availability of interpreters** for individuals, (2) teletypewriter (**TTY) functionality,** and (3) the **accuracy of plan information provided by**

customer service representatives (CSRs) in all languages. Languages tested in 2023 are unchanged from 2022 and will include English, Spanish, Cantonese, Mandarin, Vietnamese, French, and Tagalog. English will be tested as a foreign language for organizations with a service area exclusively in Puerto Rico. This study will be conducted from approximately February through June 2023.

Important definitions and exclusions for the Accuracy & Accessibility Study:

1. Interpreter availability is defined as the ability of a caller to communicate with someone and receive answers to questions in the caller's language. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) A *call* is considered connected when the caller reaches a CSR. The *measure* is considered *completed* when the caller confirms that the CSR is able to answer questions about plan benefits via an interpreter (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. CMS considers a CSR unavailable if the caller is unable to communicate with the CSR through an interpreter. The percent of completed foreign language calls (number of completed foreign language calls divided by all foreign language calls) is used for star ratings measures.

2. TTY functionality is defined as the ability of a caller using a TTY device to communicate with someone and receive answers to questions at the plan's call center directly or via a relay operator. A call is considered connected when the caller reaches a TTY/relay operator. The measure is considered *completed* when the caller confirms that the CSR is able to answer questions about plan benefits via the TTY/relay operator (before beginning the first of three general Medicare or plan-specific accuracy questions) within seven minutes of the TTY/relay operator reaching the plan. CMS considers a CSR unavailable if the caller or relay operator is unable to communicate with the CSR. The percent of completed TTY calls (the number of completed TTY calls out of all TTY calls) is used for Part C and D Star Ratings measures.

3. Contracts with *only* Special Needs Plans (SNPs) are excluded from the accuracy measure.

4. Contracts or plan benefit packages (PBPs) under marketing and enrollment sanction are excluded from the study.

In the event that an organization believes that CMS may have miscalculated its call center results based on data posted in HPMS, it may bring the relevant information to CMS' attention and ask for a review of the results. We advise organizations that they should ask for this review within 2 weeks if they do not want the data reflected in compliance actions, public reporting, or star ratings. CMS may not be able to make adjustments if issues aren't brought to its attention within 2 weeks. CMS will not revise results based on challenges to the methodology, which has been applied to all subjects of the study.

IMPORTANT ACTION: Verify 2023 Call Center Information

Compliance Officers should prepare for this monitoring effort by ensuring the accuracy of 2023 Part C and/or Part D call center telephone numbers in HPMS by **December 16, 2022**. This includes current and prospective enrollee **toll-free** beneficiary call center telephone numbers**, toll-free** pharmacy help desk numbers, and current and prospective enrollee **toll-free** TTY numbers. Telephone numbers are extracted from HPMS on a weekly basis and updated in the monitoring contractor's automated dialing software. If any of the telephone numbers change during the year, sponsors must update their telephone numbers in HPMS immediately, pursuant to 42 C.F.R. §§ 422.504(f)(2)(vii) and 423.505(f)(2)(vii). It is important that all organizations always keep these telephone numbers up-to-date in HPMS. Organizations should notify CallCenterMonitoring@cms.hhs.gov after an update is made. **If an organization achieves poor results on the measures due to calls to an inaccurate telephone numbers, the calls will not be invalidated and the results will not be negated. It is very important that accurate information is available in HPMS prior to the launch of the studies.** Use the paths outlined below to verify and/or update the telephone numbers.

Verify your pharmacy technical help desk number, which is a contract-level contact and not a bid-level contact, using the following path: HPMS home page: > Contract Management > Basic Contract Management > [select contract number] > [enter the contract number] > Contact Data > Pharmacy Technical Help Desk Contact. There are primary and secondary contacts collected in this section. The primary contact is mandatory and the secondary contact is optional. Please note that for call center monitoring purposes, we call only the primary contact.

Verify current and prospective enrollee numbers and TTY numbers through the following path: HPMS home page: > Plan Bids > Bid Submission > CY 2023 – Manage Plans > Edit Contact Data.

Follow these steps when editing contact information in the HPMS:

1. On the Select a Contract screen, enter a contract number into the field provided (Option 1) or select a contract number (Option 2). Click Next to advance to the Update and Save Data screen.

2. On the Update and Save Data screen, select a plan, and select a contact tab.

3. Edit the mailing address, telephone numbers, and e-mail address for applicable contracts.

4. After entering data for the first contact type, the user can complete data entry for other contact types under the same plan.

Notes:

- The above process to verify the accuracy of call center telephone numbers is separate from the Call Center Indicator activity that has already begun. You should have received communication from **CallCenterIndicators@insightpolicyresearch.com** in November 2022. The Call Center Indicators identify plan benefit package (PBP) phone numbers that are served by the same physical call center. This information is important as the Accuracy and Accessibility study is conducted at the call center level, with legal entities

sharing results of calls placed to a shared call center, with a limited exceptions. The Timeliness study is conducted at the phone number level. Results of calls placed to a shared phone number are shared by all legal entities utilizing that phone number, with limited exceptions. The Accuracy and Accessibility study indicators do not impact the Timeliness study. Please be aware that while phone numbers must be kept current in HPMS, the Accuracy and Accessibility study indicators cannot be updated after the Call Center Indicator collection activity is completed

- Our regulations at 42 C.F.R. §§ 422.111(h)(1) and 423.128(d)(1) require the operation of a toll-free customer call center; MMPs also have state-specific marketing guidance that requires the toll-free number. ***Even if HPMS does not denote this as a required field in your view, having toll-free numbers available is required.*** Contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028 if you require assistance.

- **All TTY numbers must be either three numeric characters or ten numeric characters and entered into HPMS.**

  Please make certain you have entered into HPMS the **TTY local telephone number** and the **TTY toll- free telephone number.** If your plan does not use a dedicated, in-house TTY device, you may enter 711 in both fields, or you may enter the toll-free ten-digit number for a specific state relay service. The toll-free TTY telephone number must be populated, as this is the telephone number we pull for the Accuracy & Accessibility Study.

  This information can be found in Chapter 1 of the CY2023 Bid User Manual (*HPMS home page > Plan Bids > Bid Submission > CY2023 > View Documentation (under "Documentation" Section) > Bid Submission User manual for Contract Year 2023*).

Tips for Success/Best Practices

Based on several years of study results, CMS provides the following tips to help improve results.

General:

- Provide basic services and information to individuals with disabilities, upon request.

- Make available all plan materials and information, including those produced or distributed by contracted providers, in alternate formats (e.g., braille, large print, audio and data CDs, and in requested alternate languages) to individuals with disabilities upon request.

We monitor thousands of plans whose IVR options are all unique. This means it is not practical or possible to train our interviewers to always make the same selection in an IVR, and we cannot program what options they should select for each plan. We train them to listen for options such as "current members," "pharmacy," or an option for those "interested in learning more about enrolling" for prospective calls, for example. When you are setting up your IVR options, please

keep this in mind. We suggest that you train your representatives to offer a warm transfer to the correct department if a caller is misdirected. You may experience more successful call outcomes if the representative offers a warm transfer, allowing us to reach a representative who can answer our question. Simply saying, "You need to call another number" or answering "no" to the introductory question, "Are you the right person to answer questions about…." will result in an unsuccessful call outcome. We call the telephone number listed in the HPMS as provided by the plan and make the most reasonable selection in the IVR, so we expect to reach a CSR who can answer questions about the plans, or at least transfer us to the correct party who can answer those questions.

HPMS Entries:

- Current, prospective, and TTY/relay services customer service call center toll-free telephone numbers must be entered in the appropriate locations in HPMS. There is a toll-free field for TTY or Telecommunications Relay Service (TRS) telephone numbers. CMS extracts the values found in the toll-free *and* alternate toll-free fields, so please make sure HPMS reflects accurate contact information and is complete in every field. If you have updates at any time during the year, please enter them into HPMS immediately. A delay in updating the telephone number(s) prior to the start of the study may result in unsuccessful calls attributed to your plan's performance. Calls of this nature cannot be negated.

Ability to Accept Calls:

- Callers to current enrollee and prospective enrollee customer service call centers need to be able to communicate with a live person when they call from 8:00 a.m. to 8:00 p.m. Messages that ask a caller to leave their telephone number are not appropriate and will not be counted as a successful call.

- CMS' monitoring reveals that our callers experience longer-than-normal hold times at the beginning of the year. Generally speaking, CMS also notes longer hold times at the beginning of a week with improvement as the week progresses. Call centers should evaluate their own needs and consider increased staffing during busier times.

- If your organization intends to implement any new technology affecting telephone systems, ensure it will not interfere with the organization's ability to accept calls, including TTY communications.

- CMS makes the following suggestions for self-monitoring your call centers on a regular basis:
    - Test every telephone number supported by the call center.
    - Pull the telephone numbers from HPMS and ensure they ring to the intended location.
    - Test by making calls from outside the organization's telephone systems. If the plan is located off the mainland, have someone place test calls from the mainland to the plan.

- Test with more than one caller at the same time.
- See TTY section below for specific TTY testing suggestions.

- CMS will occasionally solicit volunteers for abbreviated training periods prior to the beginning of an actual study launch. This is done by randomly selecting organizations to ask if they wish to volunteer. If you are launching new technology in your call center, consider joining a pilot or interviewer training session to ensure your equipment is working as expected. Contact CallCenterMonitoring@cms.hhs.gov to discuss your desire to participate in the next pilot or interviewer training session.

- **Ensure that your organization does not employ IVR logic or other functions that will block calls at certain times based solely upon the area code of the caller.** CMS generally calls from the Eastern time zone. We call regions from the Atlantic time zone to as far west as Guam. We will call you during the business standard hours of operation (8:00 a.m. to 8:00 p.m. in the time zone(s) the plan serves). If our caller cannot reach a live representative due to programming on your end, or we hear messages stating the office is closed during the required hours of operation, the call will be counted as unsuccessful.

- Carefully review your service areas to ensure you are covering the call center is open and provides services at least in accordance with standard business practices. This means that the current and prospective enrollee call centers are open minimally from **8:00 a.m. to 8:00 p.m. for all of your plans' local service areas.** Check carefully to verify your coverage for any counties that are split into two time zones or to confirm observance of daylight savings time. For example, some contracts will occasionally serve counties that are split into two time zones. Also, most of Arizona is exempt from daylight savings time. However, the Navajo Nation lands, which extend to the states of Arizona, New Mexico and Utah, observe daylight savings time. Regardless of whether two time zones are served or daylight savings time is or is not observed, call centers are required to be open minimally from 8:00 a.m.to 8:00 p.m. in all local service areas for all of its current or potential enrollees.

- **Ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu. This is important for both studies.** Every year CMS encounters plans that offer limited IVR options without a clear way to select the option to speak with a current member representative or a prospective beneficiary representative, and the IVR message cycles over and over without a live representative answering the telephone. This results in unsuccessful calls due to time-outs. Test your systems. When planning the IVR choices, ask yourself, "If I am calling to get information so I can decide if I want to enroll in this plan, is there an IVR option for me on this prospective beneficiary telephone number?"

- Ensure callers with a private number are able to connect to your plan's customer service telephone numbers.

- Train CSRs to answer the introductory question asked of them ("Are you the right person

to answer questions about…?") When we call current member customer service lines, we only ask a question intended to determine if we have reached a person who has authority to answer questions about the Medicare plan we are calling. **If the CSR insists on first knowing the caller's name, date of birth, membership ID number, or Social Security Number or refuses to answer the introductory question by stating "no," the call will be counted as an unsuccessful call unless the party transfers the call to a person who can answer "yes" in a timely manner.** Note that we only need to confirm we have reached a CSR who has authority to answer questions so we can measure the average hold time to reach a live CSR, but we do not ask any actual benefit-related questions when we call the *current member* customer service line or the pharmacy technical assistance help line.

Interpreter Availability:

- Utilize an interpretation service to identify the beneficiary's language.

- Use interpreter services personnel who are familiar with healthcare terms and Medicare benefit concepts.

- Interpreters should:
  - Adhere to generally accepted interpreter ethics principles, including confidentiality;
  - Demonstrate proficiency in speaking and understanding at least spoken English and the spoken language in need of interpretation; and
  - Interpret effectively, accurately, and impartially, both receptively and expressively, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

- Train CSRs to connect foreign-language callers with an interpreter.

- Ensure CSRs stay on the telephone when a foreign-language interpreter joins the call.

- In order to replicate a beneficiary's actual experience, CMS telephone interviewers who are testing a language other than the primary language will not make a selection in the IVR system if the instruction is only in the primary language. **Therefore, ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu.** If the IVR instruction is available in the language being tested, the test callers will make an appropriate IVR selection. For example, if the language being tested is French, *and instruction is available in French in the IVR* to select an option for French, the test caller will make that selection. (Please note that the primary language in Puerto Rico is Spanish and English elsewhere. When testing calls in Puerto Rico, English is considered a foreign language.)

- Include a note on the beneficiary's call center record that indicates his/her preferred language, if other than English, for both written and verbal communication. Record and maintain that information in a tracking system to be used in future beneficiary contacts.

- Monitor CSR calls to ensure that foreign-language calls are being handled according to the plan sponsor's policies and procedures.

- Ensure that interpreters are available within 8 minutes of the caller reaching a CSR.

- Ensure that CSRs are able to respond promptly to questions. Each accuracy question has a 7-minute timer.

TTY Functionality:

- CMS makes the following suggestions for testing in-house TTY devices:
  - Regularly test your device to ensure that it is working properly.
  - Have outside callers call in and test the system. (If in Puerto Rico, Guam, or island off the mainland, have someone on the mainland call into your TTY system to test.)
  - Have two callers from outside the system call at the same time to make sure there is no disruption on either call, calls don't get disconnected, or garbling does not occur.
  - When testing, check for garbled language on both sides of the call.
  - Whenever you make a telephone system change, retest all TTY systems.
  - If you have an outgoing message on your in-house TTY system that states to callers that if they called this number by accident, they should call the main number instead at xxx-xxx-xxxx, confirm that a TTY-recognized call will roll over to a TTY operator. This should be tested by calling from a telephone line *and* a TTY line.
  - Verify with your telecom provider that TTY calling is supported, in case there are any settings on the carrier side that need to be adjusted.
  - If using TTY Voice over Internet Protocol (VOIP), analyze network bandwidth utilization to confirm no packet loss. If there is packet loss, internet speed will need to be increased.

- If using an in-house TTY device, have a staffing plan that includes coverage for the TTY device during the hours your call center is required to operate with live CSRs.

- If using an in-house TTY device, ensure CSRs always use "GA" for "Go Ahead" after s/he has communicated his or her opening remark or other response via TTY device, so the other party knows it can now safely transmit its next thought. Failure to use "GA" may confuse beneficiaries who are familiar with TTY systems and could result in a plan hanging up on a TTY caller who has not responded, because the caller is waiting for the "GA" as clearance to respond.

- Ensure that beneficiaries using relay services can reach a CSR who has been trained on how to best communicate through a relay operator.

- Ensure that TTY services are available in languages other than English.

- Ensure that CSRs communicating to beneficiaries through relay operators are able to respond promptly to questions. By protocol, each accuracy question has a 7-minute timer.

- The decision to use 711 for the national relay operator or a different 10-digit number for a state relay operator is a business decision made by the plan. If you use a state relay operator, be certain that all callers can successfully connect on that number, regardless of the caller's area code. Our test calls will generally be placed from the Eastern time zone It is the plan's responsibility to ensure that calls from any area code can be received via their relay operator.

Information Accuracy:

- Ensure that CSRs are trained on requirements of 42 C.F.R. § 422.111(h)(1) and 42 C.F.R. § 423.128(d)(1). Review the 2023 edition of *Medicare & You* to ensure your CSRs are trained on new Part C and Part D benefit information for 2023. Consider sharing the most recent *Medicare & You* with translator service provider.

- CSRs should have specific plan benefit package (PBP) level benefit and formulary data easily available.

- Because the time is limited to 7 minutes for each of the general accuracy questions, a best practice for CSRs is to speak at a high level first and offer more detail if asked.

    - When we ask our introductory question, ("Are you the right person to answer questions about…?"), it is always best for the CSR to respond "yes" or "no," meaning yes, the CSR is the correct person to answer questions about a specific plan's benefits, or no, the CSR is not the correct person to answer questions about the plan's benefits. The CSR should then offer a "warm transfer" to the caller so that he or she may speak to the appropriate person. If the CSR responds at this high level first, it will save time, especially if the caller needs to be transferred to another party. If the CSR spends a great deal of time trying to get more information from the caller, the timer may expire, resulting in an unsuccessful call in the plan's performance.

Guidance for Providing Services to Limited English Proficient Beneficiaries

CMS reminds organizations of the HHS Office of Minority Health's (OMH) *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (*National CLAS Standards*). Originally published in 2000, an enhanced version of the *National CLAS Standards* was most recently updated by OMH in October 2018. The *National CLAS Standards* offer health and health care organizations 15 action steps for providing culturally and linguistically appropriate services (CLAS). The *National CLAS Standards* are intended to advance health equity, improve quality, and help eliminate health care disparities. The Principal Standard is to "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" and serves as the overarching goal for *National CLAS Standards'* implementation. One key area is Communication and Language Assistance,

which includes: offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services (Standard 5); informing all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing (Standard 6); ensuring the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided (Standard 7); and providing easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area (Standard 8). The *National CLAS Standards* are available at ThinkCulturalHealth.hhs.gov/clas. CMS strongly encourages sponsors to review and utilize the *National CLAS Standards* and its guidance document, *The Blueprint*. To learn how to communicate in a way that considers the cultural, health literacy, and language needs of individuals, please visit OMH's free e-learning program, *The Guide to Providing Effective Communication and Language Assistance Services*. If you have any questions about the *National CLAS Standards*, please contact AdvancingCLAS@ThinkCulturalHealth.hhs.gov.

Call Center Monitoring Reference Materials

Technical Notes/Frequently Asked Questions and Data Dictionaries for each study are stored in HPMS via links in the lower left corners of the Performance Metrics pages. Please refer to pages 2 and 3 above for the location of the studies' results. This same location is where you will find these reference materials.

If you have any questions about the 2023 call center monitoring effort, please contact the Call Center Monitoring mailbox at CallCenterMonitoring@cms.hhs.gov. Do not use secure email when communicating with this resource. **CMS will not open a secure email message.** CMS monitors thousands of plans and cannot register for secure email with each entity. We never share personally identifiable information on this project. If you need to send something securely, send an email first so we can arrange a call to discuss a mutually agreeable password for the document you wish to send.

contract_id	caseid	contract_name	organization_type	CallCenterInd	erc	cas_casestatus
H0978	C0600900	SCAN HEALTH PLAN NEVADA, INC.	Local CCP	176	294.1	294

ERC_Description	finishnote	TimeCaseStarted	TimeCaseEnded
LEP: Timeout during wait for interpreter or prior to the interpreter answering the introductory question (more than 8 minutes)	Case timed out while waiting for Interpreter	2/9/2023 20:02:10	2/9/2023 20:12:55

CaseDuration	TimeCallMade	callerhangup	HangUpBy	CallEnded	CallDuration	time_logstart
10.8	09FEB23:20:02:15		Intvw	2/9/2023 20:12:46	10.5	20:02:15

date_logstart	time_logend	date_logend	Unprofessional_Behavior_Note	Interpreter_Problem_Note	ctype	clanguage	quarter	week
02/09/2023	20:12:46	02/09/2023			5	3	1	6

phone	Assigned_ contractID	Assigned_ PlanID	PLANNAME	ORGNAME	ts0_date	ts0_time	ts1_date
1-877-916-1234	H5943	2	VillageHealth (HMO-POS C-SNP)	SCAN HEALTH PLAN	02/09/2023	20:02:15	

ts1_time	ts2_date	ts2_time	ts3_date	ts3_time	ts4_date	ts4_time	ts5_date
	02/09/2023	20:02:47	02/09/2023	20:02:47	02/09/2023	20:03:06	02/09/2023

ts5_time	ts6_date	ts6_time	ts7_date	ts7_time	TTY_Phone	IVR_TIME	HOLD_TIME	LEP_HOLDTIME
20:03:45	02/09/2023	20:11:45	02/09/2023	20:12:55		31	26	480

TTY_HOLDTIME	CASETYPEIndicator	MMP_Indicator	INDSNP	resCallCount	dayofwk	timeofday	ZIPCODE	COUNTY	STATE	QUESTION1
	C	0	1	1	4	19	90051	Los Angeles	California	0

QUESTION2	QUESTION3	ANSWER1	ANSWER2	ANSWER3	A1	O_A1M1	A2	O_A2M1	A3	O_A3M1

CCETIMEZONE	TTY_TYPE	ANSWERED	IVR1	IVR2	IVR3	IVR4	IVR5	IVR6	IVR7	IVR8
PST		1	FROM HOLD							

IVR9	IVR10	IVR11	IVRResult	HOLD	LIVE	O_LIVE2M1	O_LIVE2M2	O_LIVE2M3	EndScreen	EndScreen2
				1	1	90				

Unprofessional	INTERPRET	linesttime	lineendtime
		11	23

Medicare

Part C & D

Call Center Monitoring

Accuracy and Accessibility Study

Technical Notes

Table of Contents

DOCUMENT CHANGE LOG 2
PURPOSE 2
BACKGROUND 3
CONTACT INFORMATION 4
PERFORMANCE METRICS AVAILABILITY IN HPMS 5
UNDERSTANDING THE DATA: CALL OUTCOMES COMPARED TO MEASURE OUTCOMES 5
PERFORMANCE METRICS AS DISPLAYED IN HPMS 8
CALL CENTER MONITORING DEFINITIONS 12
HPMS DISPLAY GROUPINGS 15
RAW DATA 15
DATA DICTIONARY 15
FREQUENTLY ASKED QUESTIONS 16

Document Change Log

Previous Version	Description of Change	Revision Date
2008	Added purpose section, contact information, and expanded/clarified definitions	05/15/2016
2017	Revised call and measure outcomes and provided additional detail for performance metrics shown in HPMS for 2017, including unsuccessful calls.	3/23/2017
2019	Expanded sections for Purpose, Contact Information, and Understanding the Data. Added FAQs.	06/30/2019
2021	Revised language to match the Call Center Monitoring Memo, and expanded/clarified definitions	07/20/2021
2022	Revised based on 42 CFR 422.111(h) and 423.128(d)	06/30/2022

Purpose

This document describes the Medicare Part C and Part D Call Center Monitoring metrics for the yearly Accuracy and Accessibility Study. All results are reported at the contract level.

Background

Each year, CMS issues an annual Call Center Monitoring Memo to all Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs), Medicare Advantage-Prescription Drug Plans (MA-PDs), and Medicare-Medicaid Plans (MMPs) affected by the Call Center Monitoring studies it performs. The memo explains that the studies are for the purpose of monitoring the performance of plan sponsors' call centers with respect to the standards adopted to implement 42 C.F.R. §422.111(h)(1) and 42 C.F.R. §423.128(d)(1). The annual memo describes the study and also offers tips to help your organization be successful. The annual memo supersedes any definitions contained in this document.

In an effort to reduce the burden on plans by reducing the number of phone calls necessary for the Accuracy and Accessibility Study, CMS selects samples across *call centers* rather than basing this study on the phone number itself. In order to select these samples, we review the toll-free prospective beneficiary customer service phone numbers listed in HPMS for your Part C and Part D prospective customer service centers. CMS' monitoring contractor, Insight Policy Research, then asks the compliance officer on record in HPMS to indicate if the customer service phone numbers route into the same or different physical call centers. The monitoring contractor then determines the number of distinct physical call centers indicated by the compliance officer and notes which phone numbers route to each unique physical call center. The contractor assigns a unique call center indicator (in other words, a numerical identifier) to each call center for use in the study.

This study is conducted at the call center indicator level by calling all toll-free prospective phone numbers for the Part C call center or the Part D call center. A simple random sample method is adopted for the Accuracy and Accessibility Study where no advance knowledge of call centers' Limited English Proficiency (LEP) and TTY services or customer service representative (CSR) performance is required. There are eight different survey modes: English, Spanish, French, Vietnamese, Mandarin, Cantonese, Tagalog, and TTY. (These modes are announced each year in the annual call center monitoring memo.) English is considered the native language we are testing for all states/territories except Puerto Rico, where Spanish is tested as the native language. For interpreter availability/LEP calls, the overall sample size is first determined at the unique phone line or call center level and the sample size for each mode is then allocated. Although TTY services utilize a separate set of phone numbers, TTY is defined as one of the survey modes and it is treated like one of the languages from the sample design perspective. Therefore, TTY calls are a subset of the total sample. Since there is no TTY call center information, TTY sample size is first built at the unique TTY phone number level. For state relay phone numbers and other TTY lines that cover a large number of contracts, the sample is selected at the TTY/ LEP call center level to get sufficient coverage for these lines.
The metrics and compliance outcomes are posted in the HPMS at the conclusion of the study. The raw data, which is available by download from HPMS, show which accuracy questions were "assigned" to plans for each case/call. Each call center is assigned a numerical call center indicator which is also shown in the raw data. All plan-level results are "rolled up"and reported out to you in HPMS by contract ID.

Results are displayed for all MAOs, MA-PDs, PDPs, and MMPs. Data were collected from contracts that cover U.S. territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only direct Contract

PFFS, National PACE (Programs for the All-Inclusive Care of the Elderly), MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers. Contracts with *only* SNPs are excluded from the accuracy measure of the Accuracy and Accessibility Study. Any plan under marketing and enrollment sanction is excluded from the Accuracy and Accessibility Study until such sanction is released.

The following categories are reported within the HPMS Call Center Monitoring Part C and Part D Prospective Beneficiary Customer Support Performance Metrics sections: TTY functionality, interpreter availability/LEP, accuracy measures, and breakouts by language tested, unsuccessful calls, and Star Ratings. The TTY functionality and interpreter availability/LEP scores are combined for Star Ratings purposes but are shown in the Call Center Monitoring data only as they relate to the Accuracy and Accessibility Study. Inquiries about Star Ratings should be referred to the Part C & D Star Ratings Team.

Contact Information

The Call Center Monitoring resource mailbox can assist you with all aspects of Call Center Monitoring, including questions or concerns related to this study. Please include the contract ID, phone number on which the call was received, and specific details such as the unique call ID found in the raw data or the date and time of the call along with your question/concern. **Please do not use secure email to communicate with us.** This project never shares personally identifiable information.

If you have questions or require information about other subject areas that overlap with Call Center Monitoring, please write to those contacts directly and cc the Call Center Monitoring mailbox.

- CMS Medicare Learning Network Team: MLNMattersTeam@cms.hhs.gov
- Part C & D Star Ratings: PartCandDStarRatings@cms.hhs.gov

Performance Metrics Availability in HPMS

Detailed results (e.g., number of calls by language, number of questions answered correctly, number of completed TTY calls, etc.) will be available in the HPMS at the following paths: (https://hpms.cms.gov):

1. For Part C results, from the HPMS home page (https://hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part C Prospective Beneficiary Customer Service > [choose date range for current study] > [enter the contract number].

2. For Part D results, from the HPMS home page (https://hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part D Prospective Beneficiary Customer Service > [choose date range for current study] > [enter the contract number].

Understanding the Data: Call Outcomes Compared to Measure Outcomes

Call outcomes and measure outcomes may differ, meaning you may have a call listed in the raw data that reached a CSR, but one of the measures included in that call was not successful. To help you understand your raw data and your results, please think about the separate phases of each call as shown below:

Phase 1: Dial
Phase 2: Connect
Phase 3: Introductory Question (Interpreter Availability/LEP or TTY measure)
Phase 4: Accuracy Measure

In phase 1 *(dial)*, we download your toll-free and alternate toll-free (TTY) calling information fromHPMS. We program it, schedule it, and then dial it.

In phase 2 (*connect*), we determine if we can reach a live CSR at the plan who can assist us with our questions. Reasons for unsuccessful calls may include (1) wrong number listed in HPMS; (2) technology barrier preventing us from connecting (e.g., all circuits are busy; please check number and try again later); (3) prolonged wait times for a representative due to high call volumes at the plan; (4) center is closed at an inappropriate time; or (5) other reasons caused by the plan or the plan's phone carrier.

Whichever type of call was scheduled (TTY, interpreter availability/LEP, or native language call) will be scored as unsuccessful if we are not able to connect to a live CSR at the plan during that scheduled call or if the CSR cannot assist us with our questions or cannot forward our call to someone who can assist. (CMS provides you with a data dictionary in HPMS. The data

dictionary provides definitions for our numerical codes in the raw data. These codes explain the outcome for you.)

Once we connect to the plan, we wait in the IVR or hold queues until a CSR is available, with certain time limits. Timers allow 10 minutes each for wait times in both hold and IVR queues for non-TTY calls. If either timer expires before we reach a live CSR, the call is unsuccessful. Whichever type of call was scheduled (TTY, interpreter availability/LEP, or native language call) will be scored as unsuccessful if we are not able to reach a live CSR.

If we connect with a live CSR within the given time parameters, the call moves into phase 3 (*introductory question*), which varies depending on the type of call being made. At this point, for foreign language calls, we also test interpreter availability/LEP and ask the introductory question. We then move to phase 4 for the accuracy measure where we ask up to three accuracy questions. For TTY calls, we test TTY functionality, ask the introductory question, and then move on to the fourth phase for the accuracy measure.

For native language calls, we ask our introductory question to ensure we are speaking with a representative in the correct department and then we move into phase 4 to ask the three accuracy questions.

- For native language the *call* is connected if we reach a live representative within the permitted time.
- The *interpreter availability/LEP measure* may have a connected, complete, or unsuccessful outcome. If we are testing interpreter availability, we place the call in a foreign language and wait for the CSR to bring an interpreter to the phone to assist the CSR in answering our introductory question. We permit eight minutes for the CSR to connect to an interpreter *and answer our introductory question*. An example of an introductory question is, “Are you the right person to answer questions about [Plan name’s] health benefits?” The *call* is considered **connected** when the caller connects with the CSR. The *interpreter availability/LEP measure* is considered ***completed*** when the CSR, via an interpreter, provides an affirmative response to the introductory question (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. Alternatively, if a CSR happens to speak the foreign language we are testing, and that representative is able to answer the questions without an interpreter’s assistance, this too would count as a **completed** interpreter availability/LEP measure outcome. In order for the *interpreter availability/LEP* measure to be **complete**, there must be true communication, meaning the CSR must answer the introductory question and be able to converse in the foreign language we are testing with or without an interpreter’s assistance. For non-SNP cases, we will then move to the accuracy measure by asking the first of three accuracy questions.
- The *TTY functionality measure* may have a connected, **complete,** or unsuccessful outcome. When we test TTY functionality, we contact the plan via TTY device either directly for in- house TTY devices or via a state or national relay operator’s assistance when the plan opts to list 711 or a state relay operator’s phone number in HPMS. If we can connect to a live CSR and they answer “yes” to the introductory question (e.g., “Are you the right person to answer questions about [Plan name’s] health benefits?”) within seven minutes,the *TTY functionality measure* is **completed**.

- For non-SNP cases, we will then move to the accuracy measure by asking the first of three accuracy questions.
- The final phase for non-SNP calls is the accuracy measure. Recall that SNPs are exempt from the accuracy measure, so for SNPs, this phase is skipped. Accuracy question outcomes are defined as either having been *answered correctly* or *answered incorrectly*. Accuracy questions *not answered* due to a timer expiring are not included in the calculation of the percentage of accurately answered questions for this measure. For this reason, not answering before the seven-minute timer expires is neutral to the plan's performance.

If we are testing accuracy *in the native language*, we simply call the plan's toll-free prospective phone number and ask the CSR "Are you the right person to answer questions about…?" and wait to ensure we hear a "yes" response before we move on to the first accuracy question. English calls placed within the United States are given seven minutes to answer the introductory question. Spanish calls paced within Puerto Rico are likewise given seven minutes to answer the introductory question. (Please note that when we call plans in Puerto Rico, where Spanish is the native language, and we ask questions in English, this is considered an interpreter availability/LEP call and not a native language call, so CSRs would therefore be given eight minutes to answer the introductory question.)

For all non-SNP call types, we ask up to three plan-specific benefit questions or general Medicare questions. The contractor knows the correct answer it should receive, and their interviewer "scores" the answer received from the CSR against the expected response. In the raw data, you will see the question we asked, the expected response, and the scoring. If an incorrect answer was provided by a CSR, we record what the CSR stated during the call in the raw data. You may use the raw data to better understand your accuracy measure scores. You should also use the raw data and results from the study as a learning experience for your CSRs. CMS recommends that you review the raw data to see what questions were answered incorrectly, and then review the correct information with your staff members as a knowledge refresher opportunity.

The raw data will show outcomes for each test call placed. The raw data will include a numerical code for the call that also explains the call outcome. Please refer to the data dictionary to help you decipher the numerical call outcome codes. The data dictionary is available for download in HPMS next to the link for the Raw Data at the bottom of the performance metrics pages. In addition to the raw data, HPMS will list the unsuccessful call in the performance metrics section as well as the reason why the call was unsuccessful.

Please be aware that certain outcome codes in the raw data imply **a call is completed!**

- **Code 295** indicates the *call* was completed, meaning that the interpreter availability/LEP or TTYmeasure (phase 3) and the accuracy questions (phase 4) were completed.
- **Code 295.2 indicates an SNP call was completed,** meaning the interpreter

availability/LEP or TTY measure (phase 3) was completed**.** (SNPs do not receive accuracy questions.)

- **Code 290.x** *(where x is filled in with a number)* indicates that interpreter availability/LEP or TTY measure (phase 3) was completed, and the accuracy measure (phase 4) was *partially* completed. This means we reached a live CSR and received a response to the introduction question, but a later measure was not able to be completed for some reason. For example, code 290.7 is defined in the data dictionary as "Partial interview - CSR could not answer accuracy question in seven minutes." This means the *call* was answered by a live person and the phase 3 measure (interpreter availability/LEP, TTY functionality, or native language call) was completed. We then moved on to the phase 4 component of the call – the accuracy measure - where a separateseven-minute timer is activated for each accuracy question. In this example, a code 290.7could mean that the CSR did not answer the first, second, or third accuracy question because a timer expired, or some other problem prevented that from happening. You can review the raw data for the individual call to determine if each question was answered and, if so, whether it answered accurately or inaccurately. The raw data also shows you if and when a timer expired for an accuracy question, meaning on the first, second, or third accuracy question. Please recall that any unanswered question has a neutral impact to the plan's performance and is not cause for concern.

Performance Metrics

The performance metrics listed below correspond with column letters in the Call Center Performance Metrics tables in HPMS.

Total Number of all Monitoring Calls – This metric is the number of all monitoring calls, including interpreter availability/LEP, TTY, and native language calls.

Total Number of Completed Monitoring Calls - This metric includes the total number of completed LEP calls, completed TTY calls, and completed native language calls (codes 295, 295.2, 290.x).

All Calls - Percentage of Completed Calls out of All Calls – This metric shows the percentage of completed monitoring calls out of the total number of monitoring calls.

Unsuccessful Calls – This section shows the call weeks, which are the calendar weeks of the year when the study was active. For example, week 1 is the first week in January. This study is normally active from approximately February through June. The chart includes a count of unsuccessful calls, the total number of unsuccessful calls during the study, and a call outcome description. For example, the reader may see an outcome description that states, "TTY seven-minute HOLD." This would imply that the call interviewer was on hold for longer than seven minutes when testing TTY functionality, and therefore the call was unsuccessful, and thus the TTY measure was unsuccessful.

A call is classified as unsuccessful for any of the following reasons:

- Phone number was called but did not answer after six rings.

- Survey could not continue; Call Center disconnected call (including hanging up).
- Survey could not continue; Call Center responded in Spanish only.
- Survey could not continue; call dropped before it rang six times.
- Survey could not continue; line did not accept incoming calls.
- Survey could not continue; message stated that the target number cannot be dialed from surveyor's area code.
- Survey could not continue; phone line problems.
- Survey could not continue; reached a number that was NOT the targeted call center (due to incorrect phone number listed in HPMS).
- Survey could not continue; reached a system filtering inbound calls.
- Survey could not continue; reached Call Center voicemail.
- Survey could not continue; received a busy signal.
- Survey could not continue; technology barrier (e.g., received a computer modem/fax machine signal, beeper/pager number, etc.)
- Survey could not continue; received a message that an identification number was needed to continue.
- Survey could not continue; received a TYY device for the hearing impaired when calling via telephone.
- Survey could not continue; received message that the Call Center was closed.
- Survey could not continue; CSR refused to answer question.
- Survey could not continue; CSR insists on member name, SSN, ID etc. to continue.
- Survey could not continue; CSR tells our interviewer to call back.
- Survey could not continue: CSR unable to answer questions about Medicare/Medicaid.
- Surveyor navigated the IVR for 10 minutes and call reached time limit.
- Surveyor was in the HOLD queue for 10 minutes and then call reached limit.
- Surveyor cannot connect to TTY operator.
- Surveyor can connect to TTY operator but cannot connect to the plan.
- Survey could not continue for other reasons*.

*When the classification "*Survey could not continue for other reasons*" is used, the interviewer includes the reason in a descriptor field. Most commonly recorded reasons include:

- Disconnected number
- CSR Offers New Number to Call

Connected and Completed Calls by Language - The languages tested were: English, Spanish, French, Vietnamese, Mandarin, Cantonese, and Tagalog. HPMS displays the total number of monitoring calls, total number of connected calls, total number of completed calls,and percentage of completed calls out of all calls.

Total Number of All Interpreter Availability/LEP Monitoring Calls – The metric shows the total number of monitoring calls placed to test interpreter availability.

Total Number of Completed Interpreter Availability/LEP Calls Out of All LEP Calls – This metric shows the total number of times that an attempt to confirm interpreter availability was completed**.**

A call is considered **connected** when the caller reaches the CSR (phase2). A call is considered **complete** when establishing contact with an interpreter (or receiving assistance through a bilingual CSR), answering the introductory question (phase 3), and then beginning the first of three general Medicare or plan-specific accuracy questions (phase 4) within eight minutes of reaching a CSR. (For example, this means the introductory question was answered "yes" before moving on to the first accuracy question in the accuracy measure.) Interpreters must be able to communicate responses to the call surveyor in the callcenter's non-primary language (Spanish in Puerto Rico and English elsewhere) about the plan sponsor's Medicare benefits.

Percentage of Completed Interpreter Availability/LEP Calls Out of All LEP Calls – This metric shows the percentage of completed LEP calls out of the total number of all LEP monitoring calls.

Total Number of TTY Monitoring Calls - This metric shows the total number of monitoring calls placed to test TTY functionality.

Total Number of Completed calls to the organization TTY number - This metric shows the total number of times that an attempt to confirm TTY functionality was completed.

Completed contact using a TTY device is defined as establishing contact with and confirming that the CSR can answer questions about the plan's Medicare Part C (or Part D) benefit within seven minutes. *Remember:* A call is considered connected for TTY cases when the caller reaches the plan.

Percentage of completed calls to the organization TTY number – This metric shows the percentage of completed TTY calls out of the total number of TTY monitoring calls.

Star Ratings Calculation - The calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within eight minutes. Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within seven minutes. The formula is as shown below.

$$\frac{\#\text{ Completed TTY calls} + \#\text{ Completed LEP calls}}{\#\text{ TTY calls} + \#\text{ LEP calls}}$$

For more info on Star Ratings: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html

Accuracy - Total Number of Medicare Questions Answered – This metric shows the total number of times the Medicare accuracy questions were *answered* within seven minutes. If an

answer was not provided before the seven-minute timer expired during the monitoring call, it was not counted in this metric.

Accuracy - Total Number of Accurate Answers to all Medicare Questions – This metric shows the total number of times a CSR provided an accurate response to the accuracy question.

Accuracy - Percentage of Accurate Answers to all Medicare Questions – This metric is the percentage of times that a Medicare question was answered accurately out of the total number of Medicare questions answered.

Foreign Language Accuracy Result – This metric is the percentage of times that a Medicare question was answered accurately out of the total number of Medicare questions answered, when those questions were asked in a foreign language.

TTY Accuracy Result – This metric is the percentage of times that a Medicare question was answered accurately out of the total number of Medicare questions answered, when those questions were asked via TTY device.

Call Center Monitoring Definitions

Accuracy Questions – During the Accuracy and Accessibility Study, CMS interviewers will ask up to three accuracy questions per monitoring call placed. Each question is allotted seven minutes to determine if the CSR is able to provide an accurate and timely response to questions based upon the approved bid submission submitted into HPMS by the plan, or to a general Medicare accuracy question. The percentage of accurate responses is calculated as the number of questions answered accurately divided by the total number of *answered* questions multiplied by 100. Note: If a CSR is unable to answer the question before the timer expires, the call ends without progressing to the next accuracy question (e.g., question number 2 or 3). The effect of a timed-out call during the accuracy measure is neutral to the plan, meaning the question was not answered accurately or inaccurately and therefore is not counted in the accuracy measure performance metric.

Hold Time
During the Accuracy and Accessibility Study, the maximum hold time for waiting in an IVR or in the Hold queue is 10 minutes for non-TTY calls.

The Hold queue is defined as the time spent on hold by the interviewer following the interactive voice response (IVR) system, touch-tone response system, or recorded greeting and before reaching a live person. After 10 minutes has expired, the system closes out the case and the interviewer assigns a status code shown in the raw data.

Interpreter Availability is defined as the percent of time that a caller was able to communicate with someone and receive answers to questions in the caller's language and ask that person questions. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) A call is

considered **connected** when the caller confirms that the call connects to the CSR. The measure is considered **completed** when contact has been established with an interpreter and the introductory question has been correctly answered within eight minutes of reaching a CSR. The interviewer may also have moved on to asking the first of three general Medicare or plan- specific accuracy questions, but this is not required for consideration as a completed interpreter availability measure. The number of completed calls out of all foreign language calls is used for compliance as well as star ratings measures.

Limited English Proficiency (LEP) – The acronym LEP is used in the performance metrics section of HPMS to indicate a call made to determine interpreter availability as part of the Accuracy and Accessibility Study.

LEP Hold Time is a code used to capture the time waiting for the interpreter. Each call is allotted eight minutes for this timer.

LEP Hold time begins after reaching a live customer service representative and ends after the interviewer has confirmed that the CSR is available and able to assist in answering questions about Medicare Part C or Part D benefits.

Missing Data - When call data are not available for a contract, HPMS will display "N/A." Reasons for missing data include technical issues and other reasons for which calls cannot be made/connected.

Phone Numbers - *Prospective beneficiary customer service lines* are called for the Accuracy and Accessibility Study. Phone numbers used in the study were extracted from data provided by MAOs, MA-PDs, PDPs, and MMPs in HPMS for prospective Part C and Part D customer service lines. Customer service numbers were extracted at the plan-level (i.e., HXXXX-001 or SXXXX-001). Extracts from HPMS are performed to update phone numbers on a weekly basis throughout this study.

Calls are made to a number during the time it is supposed to be operable, which is at least 8:00 a.m. to 8:00 p.m. (according to the time zones for the regions in which they operate) for *prospective beneficiary* customer service lines. For example, if the same phone number serves plans in both New York and California, that number received calls from 8:00 a.m. in New York until 8:00 p.m. in California. The calls received are distributed throughout the interval. Statistics for any given contract typically include all calls made to phone numbers associated with the contract.

If any *beneficiary* customer service calls were made before the hour of 8:00 a.m. in the time zone of the contract's eastern-most service area or after 8:00 p.m. in the time zone of the western-most service area, they will be excluded from the analyses for that specific contract since the contractor is not expected to maintain call center operations at those times.

Connected Calls – Generally speaking, a call is considered "connected" when the study caller reaches a live person (or connects to the plan for TTY calls) in a timely manner. The measure is considered completed when that person confirms that they are able to assist the caller with questions about Medicare Part C or Part D benefits in a timely manner.

Time Data - All time data are provided in minutes and seconds in the format of MM: SS. **All monitoring calls are placed from the Columbia, Maryland area in the Eastern Time Zone.**

When reviewing the raw data, please remember to calculate the time difference between the East Coast and your plan's region(s).

TTY functionality is defined as the percent of the time a caller using a TTY device was able to communicate with someone who could answer questions either at the sponsor's call center or via relay operator. The calculation of this measure is the number of completed contacts with the CSR divided by the number of attempted contacts.
TTY Hold Time is a code used to capture the time waiting for the TTY operator. The TTY hold time is the time between reaching the plan, either via 711/state relay operator or connecting directly to a live CSR, and the time when a live CSR confirms he or she can assist with questions about Medicare Part C or Part D benefits and the confirmation was received on the tester's TTY device. The time for waiting for the TTY operator (TTY_HOLD) is seven minutes.

HPMS Display Groupings

The Accuracy and Accessibility Study displays all cumulative results for the total study in any given year. Weekly and quarterly totals are not available.

Raw Data

The raw data that supports these performance metrics is also available in HPMS in the Part C and Part D prospective beneficiary customer service performance metrics sections. Links to the raw data are displayed immediately below the performance metrics display. MAOs, MA-PDs, PDPs, and MMPs may download the data either in an Excel document for a single contract, or as a text-delimited file for all contracts under the parent organization ID.

Data Dictionary

A data dictionary is available for you to download via link in HPMS adjacent to the link for the raw data. The data dictionary provides an explanation for numerical codes shown in the raw data.

Frequently Asked Questions

Accuracy and Accessibility Study

Question: During what time of day do you place outbound monitoring calls for the Accuracy and Accessibility Study?

Answer: Calls are made to a number during the time it is supposed to be operable, which is at least 8:00 a.m. to 8:00 p.m. (according to the local time zones for the regions in which they operate) for beneficiary customer service lines. For example, if the same phone number serves plans in both New York and California, the number receives test calls from CMS from 8:00 a.m. in New York until 8:00 p.m. in California. The calls received in that interval are distributed evenly throughout the interval. Statistics for any given contract typically include all calls made to phone numbers associated with the contract.

Where multiple time zones are served by a single call center servicing multiple contract IDs, if any beneficiary customer service calls were made before the hour of 8:00 a.m. in the time zone of the contract's eastern-most service area or after 8:00 p.m. in the time zone of the western-most service area, the call will be *excluded* from the analyses for that specific contract since the contractor is not expected to maintain call center operations at those times.

Note: Prospective beneficiary customer service lines are called for the Accuracy and Accessibility Study. Phone numbers used in the study were extracted from data provided by MA organizations and Part D sponsors in HPMS for prospective Part C and Part D customer service lines. Customer service numbers were extracted at the plan-level (i.e., HXXXX-001 or SXXXX-001). Extracts from HPMS are performed to update phone numbers on a weekly basis throughout this study.

Prior to the start of this study, CMS asked MA organizations and Part D sponsors to indicate if the prospective customer service phone numbers in HPMS routed to one or more *physical call centers* so that CMS could assign a call center indicator. *This was done in an effort to minimize the call volume to Part C and Part D prospective enrollee customer service call centers.*

Question: How are call center indicators assigned?

Answer: CMS' contractor writes to the compliance officer and asks them to assign a letter (A, B, C for example) for each physically separate, distinct call center it operates. We do this late in the year prior to the study beginning the following year. The CMS contractor then further breaks down the sample by phone numbers, plan types, etc. and assigns indicators as necessary for call completion.

This process can become quite involved for large contracts that cover SNPs, non-SNPs, MMPs, and non-MMPs. If you are confused by the raw data and you are in a large contract that covers many plan types, it may be best to send specific questions to CallCenterMonitoring@cms.hhs.gov and we will assist you.

Below are some generalities about our contractor's process:

- Calls made to call center indicators that have phone numbers dedicated to SNP plans may be handled differently. If an assigned call center indicator only includes phone numbers that are dedicated to SNP plans, there is no change. If a call center indicator includes phone numbers that are dedicated to SNP plans along with phone numbers that serve both SNP and non-SNP, at least one LEP or English call is made to the SNP-dedicated phone number. Please note that a contract with ONLY SNPs is exempt from the accuracy measure and interviewers will not ask any accuracy questions on calls under these SNP-only contracts. Contracts with both SNP and non-SNP plans will be asked accuracy questions for the non-SNP plans and no accuracy questions are asked for the SNP plans. The results are rolled up to the contract level.
- Regarding how calls are applied, our contractor reviews the counties served by each plan type and the time zones served in those local service areas. (For example, some contracts will occasionally have counties that are split into two time zones. If two time zones are served, the call center is required to be open from 8 am to 8 pm in EACH local service area/time zone.) Calls are scheduled to be placed at appropriate times. The results of the calls are applied to every contract ID *within the call center indicator* that is appropriate based upon the time the call was actually placed.

To handle a big contract which normally covers all SNPs, non-SNPs, MMPs, and non-MMP plans, our contractor needs extra steps and assumptions to make sure that it can minimize the amount of calls to the plans. These assumptions are made, for example, for contracts with

1. Some phone numbers covering both SNPs and non-SNPs.
2. Some phone numbers covering either MMPs or non-MMPs.
3. Some phone numbers covering both MMPs and non-MMPs.

When a compliance office has indicated a physical call center is shared by SNP-only and non-SNP phone numbers, calls are distributed so that the SNP-only number receives at least one call a week. In this case, TTY calls are only made to non-SNP phone numbers. When a call center only uses SNP-only phone numbers, the call center can expect six calls per week, including TTY calls. We will not ask any accuracy questions for SNP plans, so the call is considered complete when an interpreter is available and answers "Yes" to our introductory question. In contrast, for non-SNP plans we will also ask accuracy questions. Consequently, SNPs which share phone numbers with non-SNPs can also share interpreter availability/LEP performance metrics with the non-SNP plan (but NOT vice versa.)

As stated previously, this can be confusing for large organizations, so let us know if you need help by sending your contract ID and your question to CallCenterMonitoring@cms.hhs.gov.

Question: Is there an average number of phone calls placed for the Accuracy and Accessibility Study?

Answer: Each year, CMS' contractor re-evaluates the number of calls needed for statistical significance in keeping with the margin of error for this study, so the examples below should only be used as an estimate of the volume of calls that could be received in any given year.

In 2023, you could expect to receive, on average, 96 calls ***to each call center indicator***. This

total comes from an average of 6 calls each week. Those 6 calls were comprised of 1 TTY test call, 2 native language calls, and 3 foreign language calls. In 2023, we placed *approximately* 96 calls to your Part C Call Center Indicator, and approximately 96 calls to your Part D Call Center Indicator, if you were a sponsor offering Part D services.

The contractor will review the information each year to determine how many calls should be placed for that year's study.

Recall that the Accuracy and Accessibility Study is conducted at the *call center* level, not the phone number level like the Timeliness Study. Our monitoring calls include the native language (Spanish in Puerto Rico; English elsewhere), TTY, and each of the six foreign languages that we test. Note that a call center indicator could have many phone lines (e.g., 35 phone lines in 2023) and each call will be to a different phone number when there is more than one number for a call center indicator. Another thing to note is that one phone line can be associated with multiple plans.

Interpreter Availability Measure

Question: When do you release the languages for testing?

Answer: We announce the languages in our annual call center monitoring memo. We typically release this in December of the year prior to the study. The memo is announced via HPMS and is emailed to compliance officers listed in HPMS for the organizations we monitor.

Question: During the Accuracy and Accessibility Study, when testing interpreter availability, if the interviewer remains on the line for more than the eight minutes allowed, before having an ability to ask for an interpreter, would this be considered an unsuccessful – or failed – call result?

Answer: For our Accuracy and Accessibility Study, when testing interpreter availability, there are separate timers for many functions. There is one for time spent in the IVR and a separate timer for the hold queue, and there is still another timer for time waiting for the interpreter to join. Once the call is answered, our interviewer identifies if he or she encountered an IVR or a live person (sometimes a call center is set up so that a live customer service representative answers the phone rather than the IVR options). Other things our interviewer could experience are whether there was a ring but no answer or some kind of auto-dialer failure. The majority of the time they encounter an IVR. Time spent in the IVR is captured in "IVR_Time" in our raw data. For all non-TTY calls, when the interviewer encounters an IVR, the plan has 10 minutes before the test call will time out if no CSR comes to the phone. If a timer expires, the call ends and the interviewer records information to capture the call failure so it will appear in the raw data. If a live CSR *does* come to the phone before those 10 minutes expire, our interviewer then selects "Live Operator" on their screen so that the raw data will capture the time when this

occurred. The second timer is what we call the "LEP_Hold" screen if we are testing interpreter availability, with LEP meaning "limited English proficiency." This is an 8-minute timer. The interpreter should connect with the CSR and assist with answering yes to our introductory question before the 8-minute LEP Hold timer goes off; if not, the call ends due to the timer failure, and this is an unsuccessful call counted toward the interpreter availability measure.

The introductory question we ask is "Are you the right person to answer questions about [Plan name's] health (or prescription drug) benefits?" We determine the question based upon which number we dialed - the Part C prospective beneficiary line or their Part D prospective beneficiary line. If the CSR, with assistance via the interpreter, is able to respond "yes," we move on to the first of three accuracy questions. If we hear "yes" before the timer expires and move to the first accuracy question, this is a complete interpreter availability measure outcome.

To answer your question directly, if an interviewer sat on the line waiting for the plan CSR for 10 minutes in the IVR or on hold but no CSR picked up the call, the call will time out and it will be counted as *an unsuccessful call.* If the CSR answers, this is a *connected call outcome*. If the CSR cannot get the interpreter on the line and have the interpreter help to answer the introductory question before the 8-minute LEP Hold timer goes off, the call is ended, and the interpreter availability measure does not have a complete result.

Question: Regarding the rule about connecting an interpreter within eight minutes, can no single transaction be longer than eight minutes, or is this an average?

Answer: No single transaction can take longer than eight minutes. If it takes longer than eight minutes for the CSR to bring the interpreter onto the line to answer our introductory question, the timer will expire, and the call will end. This results in an unsuccessful outcome. For the interpreter availability measure to be complete, the CSR, with the interpreter's help, must be able to respond "yes" to the introductory question before the 8-minute timer expires.

Question: During the interpreter availability test, is there actually a Limited English Proficient (LEP) person on the line, or do you use bilingual agents?

Answer: We use bilingual interviewers. They are fluent in the language being tested.

Question: How is the interpreter availability performance established? Must the call be connected *and* complete? We believe this to mean:

- Caller reaches a live CSR
- CSR brings an interpreter on the line, and the interpreter relays a response to the question, "Are you the right person to answer questions about…?" and
- Caller begins to ask the first benefit question within eight minutes of reaching the CSR.

Answer: For interpreter availability, we measure both connected and completed statuses. We report both results to you in HPMS at the conclusion of the study.

To explain further, if we establish contact with your CSR while speaking in a foreign language, *the call* is connected. Then we ask an introductory question (for example, "Are you the right person to answer questions about [Plan name's] health benefits?" The CSR will then bring an interpreter to the phone to assist with answering that question. Answering the introductory question with the interpreter's assistance (or having a bilingual CSR answer the introductory question in the language being tested) within eight minutes determines the outcome of the *interpreter availability measure* (i.e., a caller was able to reach someone who could speak the caller's language and ask that person questions). Once the interpreter helps the CSR answer "yes" to this introductory question, if done within eight minutes and allowing us to move on to the first accuracy (benefit) question for non-SNP plans, we have determined that your *interpreter availability measure* is ***complete***. Once we know that a yes answer has been received, we stop measuring interpreter availability and begin measuring the accuracy component by moving on to the first of three accuracy (benefit) questions, each of which is given seven minutes to answer. So, the definition we provide of needing to move on to begin the first of three accuracy questions for a complete interpreter availability status simply shows that the introductory question has been answered and we've then moved on to the next separate measure, which is accuracy. In other words, your explanation above is a correct understanding of the interpreter availability measure.

The difference between a connected call outcome and a complete interpreter availability measure is reported for you. A number of things could cause a call to go awry and not permit the interpreter availability measure to complete. For example, sometimes the interpreter joins the call and the CSR then hangs up or gets disconnected. Sometimes the interpreter joins but then the interpreter gets disconnected. If this happens, they cannot actually answer the introductory question, so interpretation did not occur and the measure is not complete. In this scenario, a CSR could have a second interpreter join and answer the introductory question. As long as that happens within eight minutes, we could still have a complete outcome.

Question: Does the outcome of the three accuracy questions have any bearing on the interpreter availability component of the survey, or do these just pertain to the accuracy measure?

Answer: The accuracy questions only pertain to the accuracy measure. They have no bearing on the interpreter availability measure. We only count questions in our accuracy scores that were asked to and answered by the CSR. If our timer expires before the CSR can answer an accuracy question, the effect is neutral to the plan because unanswered accuracy questions are not counted in the numerator or the denominator for the accuracy measure. So, if a timer expires, the call will end but please know that this has a neutral effect on the plan's performance.

TTY Functionality

Question: Do plans have to use teletypewriters for TTY functionality?

Answer: For the purpose of this study TTY can refer to either a machine (device) or IP software. Plans must provide TTY functionality, but CMS does not direct plans on how to handle the calls.

Question: Do you ask questions in foreign languages when testing TTY functionality?

Answer: The TTY measure is conducted in English only. For plans with service areas

exclusively in Puerto Rico, please be aware that we do test TTY only in English for your plans as well.

Question: If the state or national (711) relay operator for TTY is not available or accidentally drops the call, is the outcome considered unsuccessful?

Answer: Yes, the outcome would be considered unsuccessful if the state or national relay operator is not available or accidentally drops the call.

The majority of contracts opt to use the relay operator via 711 in lieu of using in-house TTY equipment, so we want to share additional information about the monitoring experience when using a relay operator. Below is a narrative describing the process.

During the call, the 711-relay operator narrates what is happening via TTY for the contractor's interviewer as they move through the call. That way, we can capture what is happening and report those metrics for each contract. Below is a description of how it works, andinstances when a failure is or is not counted against the contract.

The interviewer uses TTY IP (Internet Protocol) to call 711. There is no ring limit for TTY calls to the relay operator.

If the call does not connect to the relay operator on the first attempt or they receive a busy signal, they may log out of the TTY program, restart if needed, and make a second attempt to connect via 711. If they cannot connect via 711 on the second attempt, they also have a toll-free number for the relay operator to be used in a third attempt. If the interviewer uses the toll-free option in lieu of 711, they are trained to leave a comment in the call notes. For example, they might include this note, "Call did not go through with 711 and used 1-800-xxx-xxxx instead." If, after a third attempt, theinterviewer is not able to connect with a TTY relay operator, the inability to connect is reported and this is counted against the contract. Codes for reporting a failure to connect via TTY are available. For example, we might see code 296.19 (TTY Could Not Connect to Relay Operator) in the raw data results. Rationale: We attempt to create an authentic experience of a Medicare beneficiary trying to receive assistance via a TTY device. Our policy is to report an unsuccessfulcall if, after three attempts, we cannot connect to the relay operator. The organization should use this feedback to evaluate its business policy for use of a relay operator in lieu of an in-house TTY device.

Once our interviewer connects using TTY IP with the relay operator at 711, we give 711 the plan's toll-free Part C or Part D prospective beneficiary customer service number to dial. There is no timer activated at this point. We ask the TTY operator to confirm the number he or she is dialing. Note: If the TTY operator dials the wrong number, the monitoring contractor opts to use its "do over" option available to try again. In this scenario, the invalidated call is not counted against the plan.

The operator will narrate what's happening by replying through the TTY software, e.g., he or shemay type "ringing."

When answered, the relay operator will relay the next options: "Thank you for calling The Example Health Plan. Please hold for next representative," or relay the IVR options available. At this point, the seven-minute TTY hold timer is initiated.

The interviewer navigates through the IVR via the relay operator by telling the operator to select X in the IVR choices, or to say "representative." If the relay operator relays information to the interviewer indicating that his or her call disconnected from the health plan when making the requested selection in the IVR, the disconnected call gets coded as such and this is counted in the results in the same manner that disconnected calls are counted for non-TTY calls.

If the relay operator indicates there has been an extended hold time and asks if we wish to call back later, the interviewer will state again, "No, please hold for a live CSR." The CMS interviewer will hold until a live CSR answers or the seven-minute TTY hold timer expires. According to the Federal Communications Commission's Telecommunications Relay Service Consumer Guide, the relay operator answering or placing a call must stay with the call for a minimum of 10 minutes to avoid disruptions to the user, and relay operators must answer 85 percent of all calls within 10 seconds. If a relay operator is unwilling to hold for the duration of our seven-minute timer waiting for a live representative to answer, the outcome is beyond CMS' control and an unsuccessful call will be attributed to the plan.

If the call successfully connects with a live CSR who can respond "yes" to the introductory question ("Are you the right person to answer questions about [Plan name's] health (or prescription drug) benefits?") before the seven-minute TTY HOLD timer expires, the TTY measure is completed and the survey continues and each of the randomly generated three accuracy questions is asked. A time stamp is set on exiting the interviewer's screen so that the length of time to answer can be determined. The TTY_HOLD timer captures the time waiting for the live CSR to respond to the relay TTY operator. We then move to asking the first of three randomly generated accuracy questions. Each accuracy question has its own seven-minute timer.

If the relay operator stops responding via TTY before the introductory question is answered "yes" and relayed to us via TTY, this counts against the contract in the form of anunsuccessful TTY outcome. For example, our interviewer is communicating and types "GA" for "go ahead" to the relay operator on our TTY software and we receive no response in return. In this case, we remain on the line until the call times out. This is counted as unsuccessful in our test forTTY functionality because we have not had true communication in the process because we are still awaiting an answer to our introductory question. Our rationale behind this is that plans needsto know how members are affected when they attempt to contact their plan via a relay operator, especially if there are TTY functionality failures occurring during this process. We want plans to have this information so that they can make informed business decisions about processes that affect their membership.

Question: If the relay operator disconnected from the TTY test call, why would CMS attribute that unsuccessful result to the plan?

Answer: All organizations are free to decide if they want to use an in-house TTY device or TTY software to handle customer service calls from members or prospective members who have a hearing or speech impairment. When a plan opts to use a state or national relay service in lieu of using an in-house device, CMS considers the relay operator to be an agent of the plan. During our test calls, if *we* disconnect the line with the relay operator, we will not count the outcome of the call in the plan's performance. If the relay operator disconnects the call or refused to wait the

entire seven minutes in use for the TTY hold timer, CMS views this the same as if the plan had disconnected the call or hung up because CMS views the relay operator as an agent of the plan, by extension. If the plan disconnects from the call with the relay operator through which we are communicating, we also count the unsuccessful outcome of the TTY call in the plan's performance because the plan caused the disconnection to occur and thus the performance should reside with the plan. Please be aware that on our TTY calls, if the plan is disconnected, we will ask the relay operator if they know what happened, meaning we ask the relay operator if they know if the CSR hung up. Oftentimes, the relay operator will not know if the line was disconnected or the CSR hung up, but they are able to confirm for us that we still have an active line of communication open with the relay service and we are still able to communicate; therefore, our interviewer did not lose the connection with the relay operator. For this reason, if the plan or the relay service is the party that is no longer available on the call, the unsuccessful outcome is attributed to the plan.

Question: How should we decide if we want to use an in-house TTY device or software or a relay service?

Plan: This is a business decision for the plan to make and CMS cannot offer an opinion. Plans should weigh the pros and cons of using an in-house TTY system versus the national 711 relay service or their state relay number.

Question: Should we list 711 or the state relay operator's number in HPMS?

Answer: You may list either number in HPMS. When 711 is dialed, the call will route to the locality of where the call is originating from. Please understand that you can dial 711 to connect to certain forms of telecommunications relay services in the United States *instead of* having to remember a ten-digit telephone number for the state relay service. Dialing 711 makes it easier for travelers to use the relay service because they do not have to remember telecommunications relay service numbers in every state.

Question: Is there anything we should do to test our in-house TTY devices or software?

Answer: CMS, through its monitoring contractor, makes the following suggestions for testing in-house TTY devices or software:

- Regularly test your device to ensure that it is working properly.
- Have outside callers call in and test the system. (If in Puerto Rico, Guam, or island off the mainland, have someone on the mainland call into TTY system to test.)
- Have two callers from outside the system call at the same time to make sure there is no disruption on either call, calls don't get disconnected, or garbling does not occur.
- When testing, check for garbled language on both sides of the call.
- Whenever you make a telephone system change, retest all TTY systems.
- If you have an outgoing message on your in-house TTY system that states to callers that if they called this number by accident, they should call the main number instead at xxx-xxx-xxxx, confirm that a TTY-recognized call will roll over to a TTY operator. This should be tested by calling from a phone line *and* a TTY line.
- Verify with your telecom provider that TTY calling is supported, in case there are any

settings on the carrier side that need to be adjusted.

- If using TTY Voice over Internet Protocol (VOIP), analyze network bandwidth utilization to confirm no packet loss. If there is packet loss, internet speed will need to be increased.

Accuracy Measure

Question: If the timer expired during our accuracy question and we were not able to answer it, is the result counted against the contract's performance?

Answer: No, the effect is neutral to the contract. During the Accuracy and Accessibility Study, CMS interviewers will ask up to three accuracy questions per monitoring call placed. Each question is allotted seven minutes to determine if the CSR is able to provide an accurate and timely response to questions based upon the approved bid submission submitted into HPMS by the plan, or to general Medicare accuracy questions. The percentage of accurate responses is calculated as the number of *questions answered accurately* divided by *the total number of answered questions* x 100. ***Note: If a CSR is unable to answer the question before the timer expires, the call ends. The effect of a timed-out call is neutral to the plan, meaning the question was not answered accurately or inaccurately and therefore is not counted in the equation since a response was not received in the allotted time.***

Question: Are we permitted to answer the three accuracy questions within 21 minutes?

Answer: No. Each accuracy question has a seven-minute timer. If the first accuracy question is not answered before the seven-minute timer expires, the call ends. The second accuracy question will not be asked. Our interviewers make several calls to each plan so organizations should have sufficient opportunity to answer accuracy questions.

Question: Why is accuracy not included in the Star Ratings?

Answer: The accuracy measure results were previously part of the Star Ratings process. In the past, the majority of plans scored high ranks and that clustered the majority of plans together with similar results, so the measure itself was deemed to be not particularly helpful in differentiating one plan from another.

Question: Is the accuracy test on the actual answer provided by the plan's CSR or on the quality of the interpreter to relay the answer in the foreign language?

Answer: Two of the goals of the Accuracy and Accessibility Study, which is performed by testing interpreter availability, TTY functionality, and accuracy of the questions asked, is to determine if interpreters are available, and to determine the accuracy of responses given to prospective members. So, we would separate the interpreter availability component from this question, as it is a given that an interpreter is available in this scenario. In regard to the accuracy questions, an interpreter must be able to respond to questions accurately, so if the interpreter did not do that correctly, this must be attributed to the plan's performance. If the response to the question is not relayed correctly due to the failure of the language interpreter with whom the plan

contracted, we believe it is everyone's best interest to report that negative result back to the plan through the failure of the accuracy question being tested. Doing so helps inform the interpretation service's performance, and the plan can use that feedback for its future business decisions. We do not score or judge the interpreter's performance throughout the call – we are only looking for the correct response to the question. We would not hold the performance of the interpreter against the plan, generally speaking, so long as the response to the accuracy question is accurate. We are always happy to hear from any plan who believes a certain result may be unfair, and we are certainly willing to investigate issues that may arise, but in the instance described above, failure to respond accurately due to the failure of the interpreter is counted against the plan in the form of incorrect response to that the question being tested.

Please know that we also place calls in the native language, so your accuracy score is comprised of us asking questions in all modes – in English via TTY, in the native language (Spanish in Puerto Rico and English elsewhere), and via an interpreter when we test interpreter availability in six foreign languages.

Question: Please provide further clarity as to the timeliness metric utilized. For example, if a CSR begins providing the answer at six and a half minutes and finishes after the seven-minute limit. Does this count as untimely?

Answer: If the answer is not provided before the seven-minute mark, yes, it would be considered to have "timed out". It might help if I describe the timers to answer your question. The Limited English Proficiency (LEP) hold timer is used when waiting for an interpreter to assist the CSR with the introductory question (an eight-minute timer), the TTY HOLD timer is used when connecting via a TTY device (a seven-minute timer), and each of the three accuracy questions utilize a seven-minute timer. The interviewer has a screen that has a timer on it that counts up to 420 seconds (seven minutes x 60 seconds) or 480 second (eight minutes x 60 seconds). When that timer goes off, the interviewer does not have the ability to change the outcome of the call ending, so the answer is yes, if someone was halfway through the answer, the result would be the same as if they had not begun to answer -- the timer goes off and there is no longer an opportunity to accept the response from the CSR.

If we are determining interpreter availability, if we have not received a yes response to the introductory question before the timer goes off, that is counted as an unsuccessful interpreter availability measure.

When we have moved to the accuracy questions, if a timer goes off, that has a neutral effect on the plans, meaning we have already had a completed call for the interpreter availability component or TTY functionality score, so that would count in a good way for the plan if that portion of the test is over. If the timer goes off during the accuracy questions, this does not negatively impact the plan because it has a neutral effect. At that stage we are determining the accuracy of the answer only. If the timer goes off before an answer was provided, we show a "time out" in the raw data. The call will end, but the result of the timer going off during an accuracy question is simply that the question was not answered. This is not counted as unsuccessful or inaccurate, in other words.

Question: Are the accuracy questions that were used in prior years published and available? I would like to pass them along to the Member Services staff to be used in training.

Answer: No, they are not published or available. CMS cannot provide them to anyone. At the conclusion of this study, you will receive the questions, the expected responses, and your actual study results. These results are stored in HPMS for you to download.

CMS emphasizes that CSRs will be assisted if they are trained on plan-specific questions (For example, "What is my copay or coinsurance for a certain service?" and "Is a certain drug on the formulary?"). It may also help if CSRs are familiar with information in the latest version of *Medicare & You*, which is available here at the following link:
https://www.medicare.gov/medicare-and-you/medicare-and-you.html

Question: We are a plan with both SNPs and non-SNPs. Our SNPs receive calls that ask only your introductory question and nothing more. Why do you do this?

Answer: SNPs are exempt from the accuracy measure, so we do not ask accuracy questions. The main purpose of the Accuracy and Accessibility Study is to determine if a plan is capable of bringing an interpreter to the phone to assist, and to test if the plan can communicatewith a "prospective enrollee beneficiary" (CMS' contractor in this case) via TTY device. It is theresults of these two measures from which the Part C and Part D Star Ratings are derived. When we call in a foreign language or via TTY device, the "main focus" of the study is underway so we can determine if the plan was able to communicate with the caller. We ask the introductory question as a means of determining if the interpreter can join the line, in other words, or the CSR can communicate via TTY device or with the 711 relay service. Because contracts with *only SNPs* are excluded from the accuracy measure (which is not part of the Star Ratings), we have no need to ask any more questions.

Calls placed in English that ask only our introductory question are used for the Timeliness Study, where we are measuring the average hold time and disconnect rates, but they are also placed during the Accuracy and Accessibility Study. To add some historical perspective on the issue of contracts with only SNPs versus those contracts with both non-SNPs and SNPs, in years past we did not include contracts with only SNPs in our Accuracy and Accessibility Study. Those contracts asked CMS to include them so that they were a part of the data collection for Star Ratings purposes, so we added SNP-only contracts back into this study to satisfy the collection of information for Star Ratings. Because contracts with only SNPs are excluded from the accuracy questions, the introductory question is all that we ask.

We test English language calls across all studies as a first step to confirming that sponsor call center representatives are accessible and can be reached in a timely manner. Then, in addition to English language calls we test for interpreter availability and TTY service during the Accuracy and Accessibility Study for the reasons stated above. Statistically, if we did not test English during the Accuracy and Accessibility Study, we would need to make significantly more interpreter and TTY calls, thus increasing the burden on call centers to obtain information that is part of the English language subset. English is a baseline measurement and although we do not take compliance actions, we do use and analyze the data.

Accuracy and Accessibility Study Raw Data

Question: Where do I find raw data for the Accuracy and Accessibility Study?

Answer: The raw data is available to you in HPMS under the performance metrics sections. This is new functionality we added to make your experience a little easier. Previously you would have requested the raw data from the Call Center Monitoring mailbox; now you can download it yourself.

For the Accuracy and Accessibility Study, you can find detailed results for your contract in HPMS by following the paths below:

1. For Part C results, from the HPMS home page (https://hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part C Prospective Beneficiary Customer Service > [choose date of study] > [enter the contract number].

2. For Part D results, from the HPMS home page (https://hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part D Prospective Beneficiary Customer Service > [choose date of study] > [enter the contract number].

Raw Data supporting the Part C and Part D performance metrics are available to you in HPMS in a link immediately below the performance metrics for the selected contract under Part C and Part D. Please access the link entitled "Raw Data for Xxxxx," with the variable being the contract ID you selected. This is available to you for a single contract as an Excel download. Also available for your convenience is a link entitled "Raw Data for All Contracts." This link will provide a download of all raw data to which you are entitled under your parent organization identification code. The multiple-contract data are available to you in a text-delimited file format. You may use this file to import into Excel, Access, or some other database product.

You will also find a link to an Excel document entitled, "Data Dictionary for Raw Data." This is a data dictionary that explains the numerical codes used within the raw data. The data dictionary also contains all of the questions asked during the Accuracy and Accessibility Study and the numerical coding that explains the answer received by our interviewers.

In addition to the above resources, CMS provided a link for you to Technical Notes for the Accuracy and Accessibility Study.

Question: How are completed and unsuccessful calls identified in the call level data? When reviewing the raw data, we are unclear on how a completed TTY or interpreter availability call is identified in the call level data. We had assumed that ERC=295 (Reached CSR/TTY/Interviewer - completed questions) identified the completed calls. However, one call has an ERC code = 290.7 (Partial interview - CSR could not answer question in seven minutes) so we interpreted that as an unsuccessful call. Is that correct?

Answer: When downloading your raw data from HPMS, you should also see a link to a data dictionary for each study just to the left of the raw data link. Please be aware that the Timeliness

Study (current enrollees) uses one dictionary, while the Accuracy and Accessibility Study (prospective enrollees) uses a different dictionary. If you ever need these, simply download from HPMS at the same time you download the raw data.

In the raw data, look for the "ERC Code" and use the dictionary to decipher the numerical codes. Both ERC = 290.X and 295 would be counted as completed calls, because the first purpose of this study is that the contracts can provide interpreters and TTY functionality – and the second purpose is to test accuracy. Both 290 and 295 codes represent the situation that our interviewer has already talked to interpreters and received the answer to the introductory question. As a result, the difference between codes 290 and 295 is just that when we ask accuracy questions, some unexpected situations can occur (such as the timer expiring before the accuracy question is answered, which is neutral to the plan). If all three accuracy questions are asked, the call will be coded as 295 (smooth completion of all parts of the call.) If something happened such as timeout or a disconnection, we will code the call as 290.X (dot X would tell us in detail what happened when asking those accuracy questions.) However, this 290 code will not hurt the plan in regard to LEP and TTY functionality scores. In addition, if something happens when asking an accuracy question (an example would be the question is not actually answered), the question will not be counted in either the accuracy, so the effect is neutral to the plan: the CSR neither answered correctly nor incorrectly.

Because the main purpose of this study is the availability of interpreters and functionality of TTY, any situations that happened after a plan already completed the availability/functionality will not hurt the plan from those perspectives. Subsequently, the code 290 is a code for a completed call with some problems that would benefit the plans to know how to improve when answering questions in the future. On the other hand, the code also tells us that at least the plan already fulfilled the minimum requirement of interpreter availability and TTY functionality.

Question: In reviewing the raw data for a prior Accuracy and Accessibly Study result, we are noticing that there is variation within the Part C rates for three of our plans, for which calls are serviced at the same call center. Because the Accuracy and Accessibility Survey is measured at the call center level, doesn't that indicate that plans with calls serviced at the same call center would receive the same rate? Would you be able to explain the variation in the rates?

Contract ID	Plan Name	Part C Rate
HXX A	Example Plan 1	94%
HXX B	Example Plan 2	94%
HXX C	Example Plan 3	92%

Answer: You are correct that this study is conducted at the call center level, unlike the Timeliness Study which is conducted at the phone number level. First, the study is based at the call center level, so we first refer to what the compliance officer told us before the study in our response for call center indicators. To explain, we ask the Compliance Officer to tell us which lines route into separate and distinct physical call centers. So, please understand that your response to that inquiry determines how many call centers are used when testing. However, there

are other considerations that will result in variation of results when applied at the contract level. For example, SNPs are not asked the accuracy questions. Non-SNPs *are* asked accuracy questions. Results are rolled up to the contract level. So, if you have a contract with ONLY SNPs, the contract will not have accuracy results. If you have multiple contracts using the same call center indicator where some contracts are SNP-only and some are a mixture of SNP and non-SNP, you will not see uniform results for the accuracy measure.

Other considerations are the counties served by the plans and those time zones they serve. I mention this because we schedule our outgoing test calls at appropriate times based upon the time zones served by those plans. To minimize burden on the call centers, we attribute the results of those calls to contracts within the call center indicator, but the results are only rolled up to the contract level *when appropriate to do so*, meaning one should not expect to see uniform rates simply because the same call center is used. Let's say your call center covers 3 time zones, and you have 1 contract with plans under it that serve all 3 time zones. In that case, all call results would be attributed to that one contract. If you have a separate contract that only covers the Eastern Time Zone, then the results from calls made from 8:00 am to 8:00 pm in Eastern Time ***only*** would be included in that contract's performance.

General Questions

Question: Who do I contact if I have questions?

Answer: If your questions are related to our call center monitoring studies, send an email with your contract ID, date of call, time of call, and include the phone number on which the call was received, if possible, to CallCenterMonitoring@cms.hhs.gov. Please do NOT send your questions via secure email. We never share personally identifiable information on this project. We monitor thousands of plans and hundreds of contracts and we do not have the resources to maintain separate registrations for all of these contracts. Thank you for your understanding.

If your questions are related specifically to Star Ratings, send your question to PartCandDStarRatings@cms.hhs.gov.

If your question is related to call center performance metrics that fed into your Star Rating, and you are not sure which team to consult, send an email to both resource mailboxes and we will work together to answer your question.

Question: Please confirm how IVR menu choices are handled when monitoring calls are made. When the menu includes an option for member services, is this the option that will be chosen for the monitoring? In other words, they won't select options such as Behavioral Health crisis lines, provider lines or nurse lines. Is that correct?

Answer: For the Accuracy and Accessibility Study, our telephone interviewers will make an IVR/menu selection for prospective members whenever that is an available option in your IVR, *and it is an appropriate choice for the type of call we are placing*. For example, if we are placing a native language call, we call your prospective phone number and listen to the options. As long as you include a choice for prospective members, sales, or for more information about the plan in your IVR call tree, we'll make that selection. We would not make selections for behavioral health lines, nurse lines, crisis lines, or other such choices. Our callers make appropriate IVR selections whenever possible, except as described below.

If the correct IVR option is not immediately obvious to our interviewers, no IVR selection will be made. For this reason, ensure your phone systems will default to a live customer service representative if no IVR option is selected or no voice command is given.

Finally, when testing interpreter availability, our interviewers are simulating the experience of a non-English-speaking caller, so if IVR instructions are not available in the language we are testing, we do not make an IVR selection because a non-English-speaking caller could not understand what is being said and could not make that IVR selection. For this reason, ensure your phone systems will default to a live customer service representative if no IVR selection is made or voice command given.

Question: We found a call coded as 297.12 in our raw data. This disposition code says, "Neither Call Center Contact nor Ring/No Answer." Why are you counting this call against our plan's performance if you didn't contact us?

Answer: CMS' duplicate raw data lists the disposition codes from the calls we make in our call center monitoring studies (see data dictionaries that explain those codes for each study). Code 297.12 is one of the codes we use when we are unable to connect to a plan. This code is used for situations like receiving a message of "all circuits are busy" or a fast-busy signal. Our contractor has a system in place that requires their survey callers to make a second attempt *for any disposition where we cannot connect to the plan*, such as 297.12. The system will not allow the caller to record the information of "Neither Call Center Contact nor Ring/No Answer" unless a second attempt has been made to connect to the plan. Only one outcome is counted "against" the plan, but two attempts are made for every call in this scenario. The call outcome is included in the performance metrics and duplicated raw data so that the compliance officer can see the outcome of those two attempted calls/1 unsuccessful call disposition for a contract. We pass along that data so the compliance officer can understand how a beneficiary would have been impacted by the inability to connect to the plan on the same date and time.

CMS's contractor has investigated to rule out any phone equipment failures, employee error, or an issue on the part of its phone carrier before the results are issued to you. CMS is not able to offer an opinion about a call disposition of no plan contact other than it could have been a phone carrier's inability to transfer the call to the call center. The plan may check with their phone carrier to determine if there were any outages during the date and time in question. If a phone carrier caused the call not to transfer to the plan, the same outcome would happen to a real prospective beneficiary attempting to call the plan, so the disposition is included, and the information is reported out with the contract's performance metrics and duplicated raw data. This is longstanding practice that meets the expectations of the study's design.

Question: Our contracts under our parent organization share a phone number. Why are the results different for one or more of our contracts?

Answer: In a situation like the one above, it is best for you to send the specific details of your question to CallCenterMonitoring@cms.hhs.gov. We will research the issue with our contractor. Things to consider are: (1) the timeliness study is based upon the phone number. The Accuracy and Accessibility Study is conducted at the *call center level.* All share results *at the contract level* but (1) One or more contracts might have been under sanction during the Accuracy and Accessibility Study and therefore would have been excluded. (2) The plan sponsor might have

changed the phone number in HPMS at some point during the study. Our contractor tracks this and can tell us when the change was made. (3) Some functions of studies do not apply to all situations. For example, contracts with *only* SNPs are excluded from the accuracy measure in the Accuracy and Accessibility Study. (4) Contracts under one parent organization may vary, especially based upon their service areas. For example, one contract may serve only the Eastern Time Zone while another contract may serve Eastern and Central Time Zones. This would mean that each could be called the same number of hours (from 8:00 am to 8:00 pm in their local service areas), but those times would be different and thus the results applicable to a certain contract may be different. (5) The compliance officer may have told us that the phone numbers route to physically distinct call centers for the Accuracy and Accessibility Study.

Question: Our compliance officer sees a compliance action in the Compliance Activity Module in HPMS, but she never received the letter herself. Is this letter valid?

Answer: Please send the specifics of your inquiry to CallCenterMonitoring@cms.hhs.gov. We will be happy to research the Compliance Activity Module and our records to determine when the letter was issued to the compliance officer. Perhaps the email notification went to a spam or junk folder? The party questioning this, could also check the HPMS performance metrics sectionto determine if the non-compliant values match what is in the letter. Aside from that, we can offer the compliance officer the suggestion that he or she determine:

- Is the email address correct in HPMS? (The CAM auto populates letters with whatever email address is available in HPMS, so make sure HPMS is accurate.)
- Add HPMS@cms.hhs.gov in his or her contacts list so the emails do not go to the junk folder; and
- Make certain the IT system he or she uses isn't blocking the email addressHPMS@cms.hhs.gov.

Question: I'm having a hard time downloading the raw data from HPMS. Can you send it to me?

Answer: Please contact the HPMS help desk at 1-800-220-2028 or hpms@cms.hhs.gov. The HPMS Team at CMS has asked that we refer folks to the HPMS help desk whenever problems occur so that they can learn what is causing the problem and what they need to do to fix it. If this does not resolve the problem, please write to us at CallCenterMonitoring@cms.hhs.gov and tell us the contract ID, the study for which you need the raw data, and the time period for that study.

Question: Our call center received a CMS test call after our center closed. We serve only the Eastern Time Zone, and we are open from 8:00 a.m. to 8:00 p.m. Your test call came in at 8:15 p.m. Why did this happen, and will the result be counted against us?

Answer: First, be sure to adjust the timing of the call in the raw data to your time zone. For the Accuracy and Accessibility Study, we call from the Eastern Time Zone. You'll need to adjust the time accordingly if your call center is located in another time zone. If the time zone is not a factor and the call was truly placed outside of 8:00 a.m. to 8:00 p.m. in your region, CMS can invalidate the call and the call's outcome will NOT be counted against your organization.

The explanation for this is our contractor schedules calls during a certain block of time. The

interviewers work through the calls scheduled one at a time. If the interviewer falls behind on their schedule due to earlier calls having longer-than-expected wait times or other issues, the auto dialer pulls up the call and dials it, and occasionally this inadvertently happens after the scheduled block of time. Please know that we do have a quality assurance process on the "back end" of the study that reviews the service areas, expected hours of operation, and times calls were placed. If any call was placed later than expected hours of operation for your call center, the call is removed from your performance metrics and the duplicated raw data we provide to you before we share the results with you. We attempt to catch them all, but if we missed one, please let us know.

We try to minimize this from happening so that we do not take up your customer service representatives' time and resources – or our resources -- but it does occasionally happen. We are implementing a way to move these calls that are scheduled but not yet placed to the following day to avoid this problem. If you ever have questions about this, be sure to let us know at CallCenterMonitoring@cms.hhs.gov. We will be happy to research the call and confirm that it gets invalidated in your results.

Question: The upcoming Christmas and New Year's Day holiday falls on a Sunday. One of my plan's will observe the holidays on the Mondays after (12/26 and 1/2). Are they permitted to use alternative technologies on these two days?

Answer: They are permitted to use alternative technologies on Thanksgiving Day and Christmas Day only, per 42 CFR §§ 422.111(h)(1)(i), 423.128(d)(1)(i). This means they will have to support their call centers on December 26 and January 2.

Note: MMPs negotiate their holiday call center coverage. MMPs holiday coverage is dictated by their state-specific marketing guidance.

Question: How long must we retain the recordings of call center calls?

Answer: Though it is not a requirement of CMS to record a phone call, if an organization chooses to record calls then those recordings would be considered a record and would be required to comply with 42 CFR 422.504.

Question: I'd like to send you a recording of a call. How can I do that?

Answer: If you can, please convert the software to .mp3 or .wav format and put it in a compressed zip file format to email to CMS. To compress the file, highlight the file, right click with your mouse, and choose "send to a compressed file." Once compressed, please email it to CallCenterMonitoring@cms.hhs.gov along with the contract ID, the phone number on which the call was received, the date and time of the call, and the details of your request. CMS uses VLC software for recording playback. This software can read several formats including 3GP, ASF, AVI, DVR-MS, FLV, Matroska (MKV), MIDI, QuickTime File Format, MP4, Ogg, OGM, WAV, MPEG-2 (ES, PS, TS, PVA, MP3), AIFF, Raw audio, Raw DV, MXF, VOB, RM, DVD-Video, VCD, SVCD, CD Audio, DVB.

Please remember to send this via regular email and not secure email. This project never shares personally identifiable information, so secure email for a CMS test call should not be necessary.

Question: We created a contingency plan in the unlikely event all systems or phones go down. We know ideally when it comes to the test calls and member experience, we never want this to happen, but we want to be prepared for all circumstances. Does CMS have guidance or best practices if an outage like this occurs? We can play a cloud message letting callers know they can call back and would accordingly self-report it to CMS, but what happens if a test call comes in? Would we fail it if we had a cloud message and self-reported it to CMS?

Answer: In regard to contingency plans and guidance, Part D sponsors and MAOs are required to have operational continuity plans in place. These requirements are described at 42 C.F.R §422.504(o) and 42 C.F.R §423.505(p). The plans for continuity of operations must include the operation of call center customer services. Therefore, if call center operations cease temporarily due to an emergency situation or disaster declaration (or as stated above due to phone outages), the MAO or Part D sponsor should implement their continuity plan. MAO/sponsor continuity plans should include contingency plans to maintain operations or if unable, to restore call center operation within 72 hours.

CMS does not have a written best practice to share, ideally sponsors should have an alternate call center to which calls could be directed. One example used by several sponsors is an auto forward to the pharmacy technical assistance call center for issues relating to prescription drugs, pharmacy billing questions, etc. To be clear, there is no specific requirement for this, and it is only offered as an example. That said, hypothetically, the calls as described *would be* non-compliant and scored as unsuccessful attempts if our test calls reach a message asking the party to call back, due to the requirement that call centers must be open during required hours of operation. This is true even if the closure was self-reported. Again, hypothetically, inappropriate call center closures may result in compliance action. Your plan to alert CMS in such an unexpected event is a good one. CMS suggests that MAOs, MA-PDs, PDPs, and MMPs self-disclose any call center closures – whether related to declarations of emergency or not -- to the assigned CMS Regional Office Account Manager. Adding CallCenterMonitoring@cms.hhs.gov as a cc would be helpful to us. Since 2006, CMS has consistently advised Part D sponsors and MAOs to report voluntarily to CMS any instances of program non-compliance that they discover on their own. As CMS staff have stated in numerous presentations to industry, we look more favorably on instances of non-compliance when it is self-reported rather than through other means, such as beneficiary complaints, complaints from competing contractors, audits, or our own data analysis. That is, CMS believes that self-reporting can be seen as evidence of an effective compliance program, indicating that while some non-compliance has occurred, the Part D sponsor or MAO has capable management and oversight in place exercising effective control over the organization.

Question: How was compliance determined for the 2023 Accuracy and Accessibility Study?

Answer: Interpreter Availability was tested to determine if the services were compliant with 42 C.F.R. §§ 422.111(h)(1)(iii) and 423.128(d)(1)(iii), which require interpreters to be available for 80 percent of incoming calls requiring an interpreter within 8 minutes. TTY functionality was tested to determine if services were complaint with 42 C.F.R. §§ 422.111(h)(1)(iv) and 423.128(d)(1)(iv), which require 80 percent of incoming calls requiring TTY services to be connected to a TTY operator within 7 minutes. Accuracy was tested to determine if the services were compliant with 42 C.F.R. §§ 422.2262(a)(1)(i) and 423.2262(a)(1)(i), which requires MA organizations and Part D sponsors not to provide information that is inaccurate or misleading.

For 2023, we determined the accuracy compliance threshold to be 90 percent. MA organizations and Part D sponsors with accuracy results below 90 percent are outliers and per 42 C.F.R. §§ 422.504(m)(2) and 423.505(n)(2), CMS may determine that an MA Organization or Part D sponsor is out of compliance when its performance in fulfilling requirements represents an outlier relative to the performance of other organizations.

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21244-1850

CENTER FOR MEDICARE

DATE: November 1, 2023

TO: Medicare Advantage Organization Compliance Officers

FROM: Vanessa S. Duran
Acting Director, Medicare Drug Benefit and C & D Data Group

SUBJECT: 2025 Quality Bonus Payment Determinations and Administrative Review Process for Quality Bonus Payments and Rebate Retention Allowances

This memorandum provides guidance on the determination of quality bonus payment (QBP) status and the administrative process available for review of those determinations.[1] In addition, this memorandum provides procedural instructions for MA organizations to seek review under 42 C.F.R. § 422.260.

Background

Sections 1853(n) and 1853(o) of the Act[2] require CMS to make QBPs to Medicare Advantage (MA) organizations that achieve at least 4 stars in a 5-star quality rating system. In addition, section 1854(b)(1)(C) of the Act ties the share of savings that MA organizations must provide to enrollees as the beneficiary rebate to the level of an MA organization's QBP rating.

Under 42 C.F.R. § 422.260, CMS has made an administrative review process available to MA organizations for payment determinations based on the quality bonuses. The 2025 QBP appeals process starts November 1, 2023 with the posting of the preliminary QBP ratings in HPMS. MA organizations may request an administrative review of their ratings for QBP determinations and rebate retention allowances. The following explains the process for requesting a review of these ratings.

Star Ratings to be Used for QBP Determinations

The Star Ratings for the 2025 QBP determinations are the 2024 Star Ratings released October 2023 on the Medicare Plan Finder (MPF) tool at http://www.medicare.gov for those contracts that had enough data to calculate an overall rating.

[1]The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.
[2] References to "the Act" are to the Social Security Act.

The methodology for determining the Star Ratings is described in 42 C.F.R. §§ 422.160 through 422.166 and 423.180 through 423.186 and the Medicare 2024 Part C & D Star Ratings Technical Notes. With the release of the Star Ratings on the MPF tool, the data were also posted at http://go.cms.gov/partcanddstarratings.

Only MA organizations are included in the QBP ratings. The MA organization types are:

Organization Type	Offers Part D
Local CCP	✓
MSA	
PFFS	✓*
Regional CCP	✓

* PFFS are not required to offer drug benefits.

QBP Rating Rules

For contracts that receive a numeric Star Rating, the QBP rating is the highest rating as defined at 42 C.F.R. § 422.162 and is assigned as follows:

- For MA contracts that offer Part D, the QBP rating is the numeric overall Star Rating.
- For MA contracts that do not offer Part D, the QBP rating is the numeric Part C summary rating.

For contracts that do not have a numeric Star Rating, the QBP rating is determined based on whether the contract is a new MA plan or low enrollment contract, as defined at 42 C.F.R. § 422.252. The message the contract received on MPF is specific to the type of contract:

- Contracts with the message "Not enough data available" on MPF are considered low enrollment contracts for assignment of the QBP rating.
- Contracts with the message "Plan too new to be measured" on MPF are considered new contracts for assignment of the QBP rating.

Low enrollment contracts, as defined at 42 C.F.R. § 422.252, are those that have been in existence long enough to receive a Star Rating but do not have enough enrollment to reliably report Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcomes Survey (HOS) data.

Under 42 C.F.R. § 422.252, a new MA plan means an MA contract offered by a parent organization that has not had another MA contract in the previous 3 years.

The following rules are used to assign QBP ratings for a new contract; these were first adopted in the 2012 Advance Notice and Rate Announcement.[3] These rules are codified at 42 CFR § 422.166(d)(2)(vi). As explained in the final rule that appeared in the Federal Register on January 19, 2021 ("Medicare and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly") (86

[3] In addition, this policy was addressed in a proposed rule for CY 2012 that appeared in the Federal Register on November 22, 2010 ("Medicare Program: Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Proposed Changes") (75 FR 71190, 71219) and the related final rule that appeared in the Federal Register on April 15, 2011 (76 FR 21432, 21486 through 21490).

FR 5864, 5929 through 5931), we codified existing and current policy without change. We follow the same steps as in prior years for calculating the QBPs after publication of the final rule.

For the 2025 QBPs, for any new contract(s) under an existing parent organization, we apply the following rule:

(i) We identify the parent organization of the new contract in November 2023.

(ii) For preliminary QBP ratings, we identify the MA contracts held by that parent organization in November 2023. We use the numeric Star Ratings issued in October 2023 for those MA contracts that are held by the parent organization in November 2023 that we anticipate will still be in existence and held by that parent organization in April 2024.

(iii) Using the enrollment in those other MA contracts as of November 2023, we calculate the enrollment-weighted average of the highest Star Rating(s) of those MA contracts.

(iv) In April 2024, we update the enrollment-weighted average rating to take into account any changes to the parent organization of the existing contracts; this includes the ratings of any contract(s) that the parent organization acquired since November 2023. The updated enrollment-weighted average rating continues to use the November 2023 enrollment in the contracts held by the parent organization in April 2024. This updated rating is used as the 2025 QBP rating for the new MA contract(s) for that parent organization for payment in 2025. This final QBP rating will be released to the MA organization for the new contract(s) in April 2024.

For any new contract(s) under a parent organization that has no MA contracts in November 2023, we apply the following rule:

(i) We identify the MA contracts held by that parent organization in November 2022. If the parent organization had other MA contracts in November 2022, we use the numeric Star Ratings issued in October 2022 for those MA contracts that were held by the parent organization in November 2022.

(ii) Using the enrollment in those other MA contracts as of November 2022, we calculate the enrollment-weighted average of the highest Star Rating(s) of those MA contracts.

(iii) This is used as the 2025 QBP rating for the new MA contract(s) for that parent organization for payment in 2025. This final QBP rating will be released to the MA organization for the new contract(s) in April 2024.

For any new contract(s) under a parent organization that has no MA contracts in November 2022 and 2023, we apply the following rule:

(i) We identify the MA contracts held by that parent organization in November 2021. If the parent organization had other MA contracts in November 2021, we use the numeric Star Ratings issued in October 2021 for those MA contracts that were held by the parent organization in November 2021.

(ii) Using the enrollment in those other MA contracts as of November 2021, we calculate the enrollment-weighted average of the highest Star Rating(s) of those MA contracts.

(iii) This is used as the 2025 QBP rating for the new MA contract(s) for that parent organization for payment in 2025. This final QBP rating will be released to the MA organization for the new contract(s) in April 2024.

For the 2025 QBPs, if there were no MA contract(s) for the parent organization with numeric Star Ratings in the previous three years (i.e., November 2021, 2022, and 2023), the contract is treated as a new MA plan in accordance with 42 C.F.R. § 422.258(d)(7) for payment purposes.

Any changes in a contract's parent organization that occur from the annual verification (due by March 15, 2024) will be reflected in the final QBP ratings released in April 2024. The same parent organization rules outlined above are applied to the contract using the new parent organization information. Once the QBP ratings are finalized in April 2024, no additional parent organization changes are possible for QBP purposes. The QBP rating is applied to each plan benefit package under the contract.

The enrollment used in the calculations is the enrollment in the contract used for payment by CMS in November of the year the Star Ratings are released. Since the 2024 Star Ratings were released in the fall of 2023, the November 2023 enrollment is used for both the preliminary 2025 QBP ratings (released in November 2023) and the final 2025 QBP ratings (released in April 2024). The enrollment data are posted publicly here: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html.

Under 42 C.F.R. § 422.162(b)(3), in the case of contract consolidations involving two or more contracts for health or drug services of the same plan type under the same parent organization that are approved on or after January 1, 2024 and for which 2025 is the first year of the consolidation, CMS will update the QBP status of the surviving contract using the enrollment-weighted average of what would have been the QBP ratings of the surviving and consumed contracts based on contract enrollment in November 2023. The updates will be available in spring 2024 for bid submissions.

Viewing QBP Ratings

All MA contracts with Star Ratings data (those with numeric Star Ratings and new contracts under existing parent organizations) should view their Star Ratings for QBP purposes in HPMS by selecting Quality and Performance in the navigation bar, then Performance Metrics, then Reports, then Costs, then MA QBP Rating. Contracts should ensure that 2025 is selected as the "Report Period" and then click "Create Report" to view their QBP ratings. Select "Download to Excel" to download the Request for Reconsideration form. QBP details for contracts without Star Ratings data (low enrollment contracts and new contracts under new parent organizations) are not part of the appeals process because such contracts have no data to appeal and their QBPs are assigned based on 42 C.F.R. § 422.258(d)(7)(iv) and (v).

During the 2024 Star Ratings preview periods in August and September 2023, MA organizations had the opportunity to raise questions about the calculation of the Star Ratings and the underlying data. CMS anticipates that issues addressed during the preview periods will reduce the number of MA organizations requesting an administrative review of QBP determinations. Note, however, that asking questions during the preview periods is not part of the formal appeals process.

Administrative Review Process for QBP Determinations

Section 422.260 provides for a two-step administrative review process that includes a request for reconsideration and a request for an informal hearing on the record after an adverse reconsideration

decision. Both steps are conducted at the contract level. The first step allows the MA organization to request a reconsideration of how its contract's Star Rating was calculated and/or what data were included in the measure(s). If the MA organization is dissatisfied with CMS' reconsideration decision, the MA organization may request an informal hearing to be conducted by a hearing officer designated by CMS.

Scope of an Administrative Review

Under 42 C.F.R. § 422.260(c)(3)(ii), an administrative review cannot be requested for the following: the methodology for calculating the Star Ratings (including the calculation of the overall Star Ratings), cut-off points for determining measure thresholds, the set of measures included in the Star Rating system, and the methodology for determining QBP determinations for low enrollment and new plans. Therefore, requests for reconsideration and an informal hearing may be filed for QBP purposes only under a limited set of circumstances.

Permissible bases for requests for both types of reviews include a calculation error (miscalculation) or a data inaccuracy (incorrect data). A calculation error could impact an individual measure's value or the overall Star Rating. Requests should focus on issues that could result in increased star values, as increased measure values that result in the same Star Rating are unlikely to change an MA organization's QBP rating. MA organizations are reminded that administrative reviews for measures for which the organization already receives 5 stars will not result in an increase in an organization's QBP rating, and could result in the rating going down if a calculation error or data inaccuracy is identified.

If an MA organization believes the wrong set of data was used in a measure (i.e., following a different timeframe than the one in the measure specifications as adopted in the applicable final rule and subject to updates as permitted by 42 C.F.R. § 422.164(d)), this is considered a calculation error. A request for review based on data inaccuracy may only be filed for a subset of measures. Attachment A includes information about whether a contract may request a review based on data inaccuracy (incorrect data) for each of the measures included in the Star Ratings. Generally, the contract may not request a review based on data inaccuracy for the following data sources:

- HEDIS measures, which were audited prior to submission to CMS;
- Measures based on beneficiary feedback, including data collected through CAHPS, HOS, and the Complaints Tracking Module (CTM);
- Plan-reported data, including SNP Care Management, Medication Therapy Management, Prescription Drug Event data, and Plan Finder pricing and pharmacy data;
- Contract enrollment data from HPMS or MARx because CMS information is the system of record for enrollment; and
- Other federal data sources (e.g., FEMA).

Note: Before an MA organization requests an administrative review, it is important to consider that a change in data values for a measure may not necessarily change the Star Rating for that measure or the overall Star Rating for the contract. Since Star Ratings for a measure are based on cut points, a significant change in the data is usually required in order for a contract to move from a lower Star Rating to a higher one. Even if there is a change in the Star Rating for one or more measures, the contract's overall Star Rating may not change because the change to a single measure is not often significant enough to move it to the threshold for the next higher overall Star Rating. Please review the cut points for Part C and D measures in the Medicare 2024 Part C & D Star Ratings Technical

Notes. This information will help an organization determine whether requesting an administrative review will be beneficial.

Request for Reconsideration under 42 C.F.R. § 422.260(c)(1)

As stated above, the administrative review is a two-step process that begins with a request for reconsideration. **This review is not intended to repeat the preview periods in giving contracts another opportunity to raise general questions about how CMS calculates the Star Ratings, nor is it intended to review how every measure was calculated.** Instead, this review affords an MA organization the opportunity to request review of specific measure values that may affect the calculation of the contract's QBP.

Per 42 C.F.R. § 422.260(c)(1)(i), the request for reconsideration must specify the given measure(s) in question and the basis for reconsideration. The alleged error could impact an individual measure's value or the overall Star Rating. The request must include the specific findings or issues with which the contract disagrees and the reason for the disagreement; we recommend including specific examples of the miscalculation and/or data inaccuracy if relevant. The request for reconsideration may include additional documentary evidence that the MA organization would like CMS to consider.

In conducting the reconsideration, the reconsideration official will review the QBP determination, the evidence and findings upon which it was based, and any other written evidence submitted by the organization or by CMS before the reconsideration determination is made. CMS will inform the MA organization of the reconsideration official's decision through electronic mail. The reconsideration official's decision is final and binding unless a request for an informal hearing is filed in accordance with the instructions provided with the reconsideration official's decision.

Request for a QBP reconsideration is made by completing **the Excel version of the form shown in Attachment A**, "Request for Reconsideration" available in HPMS by selecting Quality and Performance in the navigation bar, then Performance Metrics, then Reports, then Costs, then MA QBP Rating. The contract must email the completed Excel form to QBPAPPEALS@cms.hhs.gov by **5:00 p.m. EST on November 17, 2023**. The file should include the contract number as part of the file name. A request for reconsideration must be submitted by the date and time above in order to reserve the right to later request an informal hearing. **Please ensure you receive confirmation from the mailbox that your request was received.**

Informal Hearing under 42 C.F.R. § 422.260(c)(2)

The MA organization seeking an appeal of the reconsideration official's decision regarding its QBP status must do so by providing written notice to CMS within 10 business days of the issuance of the reconsideration decision; instructions for requesting an informal hearing will be provided with the reconsideration decision. An informal hearing request may not be made unless a reconsideration was first requested and the decision sent to the MA organization. The informal hearing request must pertain only to the measure(s) and value(s) in question that precipitated the request for reconsideration. Requests must include a statement that describes the error(s) that the MA organization asserts CMS made in its QBP determination and how correction of those errors could result in the organization's qualification for a QBP or a higher QBP.

Per 42 C.F.R. § 422.260(c)(2)(v), the MA organization must provide clear and convincing evidence that CMS' calculations of the measure(s) and value(s) in question were incorrect; in other words, the burden is on the MA organization to prove an error was made in the calculation of the QBP.

CMS will attempt to complete all informal hearings by early April; however, decisions could be issued as late as May 15 of the year preceding the year in which the QBP is to be applied. CMS is aware a May 15 deadline is necessary to afford MA organizations time to incorporate their QBP status into their plan bids, due by the first Monday in June. The hearing officer's decision is final and binding on both the MA organization and CMS.

Changes from the Administrative Review Process

If the hearing officer's decision is in favor of the MA organization, the MA organization's QBP is recalculated using the corrected data and applying the rules at 42 C.F.R. §§ 422.160 through 422.166. **Recalculation could cause the requesting MA organization's QBP to go higher or *lower*.** In some instances, the recalculation may not result in the Star Rating rising above the cut-off for the higher QBP rating. Under 42 C.F.R. § 422.260(d), CMS may revise an MA organization's QBP status at any time after the initial release of the QBP determinations through April 1 of each year on the basis of any credible information, including information provided during the administrative review process that demonstrates that the initial QBP determination was incorrect. When the reconsideration official or hearing officer's decision requires that a measure be systematically recalculated for all contracts, all other affected contracts (i.e., contracts of other MA organizations) are recalculated using the corrected data and applying the rules at 42 C.F.R. §§ 422.160 through 422.166; other affected contracts are assigned the recalculated Star Rating if it results in a higher Star Rating, and any resulting changes would be made to the Star Ratings and QBPs for all affected contracts. Contracts' 2024 Star Ratings, which are used for 2025 QBPs, will not be decreased by CMS as a result of a systematic re-calculation; however, the issue will be addressed in the next year's Star Ratings.

Any questions regarding this memo may be submitted to QBPAPPEALS@cms.hhs.gov.

Please do not send messages requiring CMS to login to another site to access the questions or message content. If you need to share personally identifying information (PII) with us, please contact us with a regular email to discuss a safe way to transfer the secure data.

Attachment A

Request for Reconsideration

Note: The QBP administrative review process is a two-step process that includes: 1) a request for reconsideration, and 2) a request for an informal hearing after CMS has rendered its reconsideration decision. Both steps are conducted at the contract level. This first step affords an MA organization the opportunity to request a reconsideration of how its Star Rating, for the given measure in question, was calculated. This is not an opportunity for an MA organization to question how every measure was calculated. A request for reconsideration must be submitted by the date and time specified below in order to reserve the right to later request an informal hearing on the record.

Instructions: Use only the "Request for Reconsideration" form that can be found in HPMS. To download a copy of the form from HPMS, select Quality and Performance on the home page, then Performance Metrics. On the Performance Metrics page select Reports, Costs, and then MA QBP Rating. One form must be submitted for each contract for which reconsideration is requested. Complete the identifiable information including all contact information. Mark an "X" next to the measure(s) that the MA organization is questioning and requesting reconsideration. In the "Description of the Issue" specify any errors that the MA organization asserts CMS may have made in calculating the contract's QBP determination. Save the information, please include your contract number in the filename, and e-mail the completed form along with any additional documentary evidence to be considered to QBPAPPEALS@cms.hhs.gov by the due date.

Due Date: A Request for Reconsideration of QBP is made by completing the Excel version of this form downloaded from HPMS and e-mailing the form to QBPAPPEALS@cms.hhs.gov by 5:00 p.m. EST on **November 17, 2023**. No late requests will be accepted.

Contract Number (5 character CMS assigned code):	
Contact First Name (your first name):	
Contact Last Name (your last name):	
Contact Title (your job title):	
Contact Phone Number (your phone number, include extension if necessary):	
Contact email address (your email address):	

Overall Rating	Data Source	Request for Reconsideration Indicate with "X"		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
QBP/Overall Rating	Star Ratings		Not Appealable	

Part C Measures	Data Source	Request for Reconsideration Indicate with "X"		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that
		Miscalculation	Incorrect Data	

				Incorrect data were used)
C01 - Breast Cancer Screening	HEDIS		Not Appealable	
C02 - Colorectal Cancer Screening	HEDIS		Not Appealable	
C03 - Annual Flu Vaccine	CAHPS		Not Appealable	
C04 - Monitoring Physical Activity	HEDIS / HOS		Not Appealable	
C05 - Special Needs Plan (SNP) Care Management	Part C Plan Reporting		Not Appealable	
C06 - Care for Older Adults – Medication Review	HEDIS		Not Appealable	
C07 - Care for Older Adults – Pain Assessment	HEDIS		Not Appealable	
C08 - Osteoporosis Management in Women who had a Fracture	HEDIS		Not Appealable	
C09 - Diabetes Care – Eye Exam	HEDIS		Not Appealable	
C10 - Diabetes Care – Blood Sugar Controlled	HEDIS		Not Appealable	
C11 - Controlling Blood Pressure	HEDIS		Not Appealable	
C12 - Reducing the Risk of Falling	HEDIS / HOS		Not Appealable	
C13 - Improving Bladder Control	HEDIS / HOS		Not Appealable	
C14 - Medication Reconciliation Post-Discharge	HEDIS		Not Appealable	
C15 - Plan All-Cause Readmissions	HEDIS		Not Appealable	
C16 - Statin Therapy for Patients with Cardiovascular Disease	HEDIS		Not Appealable	
C17 - Transitions of Care	HEDIS		Not Appealable	
C18 - Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS		Not Appealable	
C19 - Getting Needed Care	CAHPS		Not Appealable	
C20 - Getting Appointments and Care Quickly	CAHPS		Not Appealable	
C21 - Customer Service	CAHPS		Not Appealable	
C22 - Rating of Health Care Quality	CAHPS		Not Appealable	
C23 - Rating of Health Plan	CAHPS		Not Appealable	
C24 - Care Coordination	CAHPS		Not Appealable	
C25 - Complaints about the Health Plan	CTM		Not Appealable	

C26 - Members Choosing to Leave the Plan	MBDSS		Not Appealable	
C27 - Health Plan Quality Improvement	Star Rating		Not Appealable	
C28 - Plan Makes Timely Decisions about Appeals	IRE			
C29 - Reviewing Appeals Decisions	IRE			
C30 - Call Center – Foreign Language Interpreter and TTY Availability	Call Center			
Part D Measures	Data Source	Request for Reconsideration Indicate with "X"		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
D01 - Call Center – Foreign Language Interpreter and TTY Availability	Call Center			
D02 - Complaints about the Drug Plan	CTM	Not Applicable	Not Applicable	Not appealable, use Part C measure C25 above.
D03 - Members Choosing to Leave the Plan	MBDSS	Not Applicable	Not Applicable	Not appealable, use Part C measure C26 above.
D04 - Drug Plan Quality Improvement	Star Ratings		Not Appealable	
D05 - Rating of Drug Plan	CAHPS		Not Appealable	
D06 - Getting Needed Prescription Drugs	CAHPS		Not Appealable	
D07 - MPF Price Accuracy	PDE data		Not Appealable	
D08 - Medication Adherence for Diabetes Medications	PDE data		Not Appealable	
D09 - Medication Adherence for Hypertension (RAS antagonists)	PDE data		Not Appealable	
D10 - Medication Adherence for Cholesterol (Statins)	PDE data		Not Appealable	
D11 - MTM Program Completion Rate for CMR	Part D Plan Reporting		Not Appealable	

D12 - Statin Use in Persons with Diabetes (SUPD)	PDE data		Not Appealable	
Additional Comments (Please provide any additional information relevant to your request)				

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1129 and form number CMS-10346 (Expires: 8/31/2024). The time required to complete this information collection is estimated to average 8 hours, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

SCAN-AR00096

Attachment B - Request for Informal Hearing

Note: The QBP administrative review process is a two-step process which includes: 1) a request for reconsideration, and 2) a request for an informal hearing after CMS has rendered its reconsideration decision. Both steps are conducted at the contract level. The burden is on the MA organization to prove that the reconsideration decision was incorrect.

Instructions: Use only the "Request for Informal Hearing" form provided with the reconsideration decision. One form must be submitted for each contract for which reconsideration is requested. Complete the identifiable information including all contact information. Please enable Macros in this form. Mark an "X" next to the measure(s) that is the basis for the Request for Informal Hearing. Do not mark any measures for which you did not request a reconsideration. Please attach full documentation that supports your request for an informal hearing on the record. Save the information, include your contract number in the filename, and e-mail the completed form along with any additional documentary evidence to be considered to QBPAPPEALS@cms.hhs.gov by the due date.

Due Date: A Request for Informal Hearing is made by completing this form and e-mailing the form to QBPAPPEALS@cms.hhs.gov by 5:00 p.m. EST on February 29, 2024. No late requests will be accepted.

Contract Number (5 character CMS assigned code):	H5425
Contact First Name (your first name):	Michael
Contact Last Name (your last name):	Plumb
Contact Title (your job title):	Chief Financial Officer
Contact Phone Number (your phone number, include extension if necessary):	714-655-9202
Contact email address (your email address):	mplumb@scanhealthplan.com

Overall Rating	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
QBP/Overall Rating	Star Ratings		Not Appealable	

Part C Measures	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
C01-Breast Cancer Screening	HEDIS		Not Appealable	
C02-Colorectal Cancer Screening	HEDIS		Not Appealable	
C03-Annual Flu Vaccine	CAHPS		Not Appealable	
C04-Monitoring Physical Activity	HEDIS / HOS		Not Appealable	
C05-Special Needs Plan (SNP) Care Management	Part C Plan Reporting		Not Appealable	
C06-Care for Older Adults – Medication Review	HEDIS		Not Appealable	
C07-Care for Older Adults – Pain Assessment	HEDIS		Not Appealable	
C08-Osteoporosis Management in Women who had a Fracture	HEDIS		Not Appealable	
C09-Diabetes Care – Eye Exam	HEDIS		Not Appealable	
C10-Diabetes Care – Blood Sugar Controlled	HEDIS		Not Appealable	
C11-Controlling Blood Pressure	HEDIS		Not Appealable	
C12-Reducing the Risk of Falling	HEDIS / HOS		Not Appealable	
C13-Improving Bladder Control	HEDIS / HOS		Not Appealable	
C14-Medication Reconciliation Post-Discharge	HEDIS		Not Appealable	
C15-Plan All-Cause Readmissions	HEDIS		Not Appealable	
C16-Statin Therapy for Patients with Cardiovascular Disease	HEDIS		Not Appealable	
C17-Transitions of Care	HEDIS		Not Appealable	
C18-Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS		Not Appealable	
C19-Getting Needed Care	CAHPS		Not Appealable	
C20-Getting Appointments and Care Quickly	CAHPS		Not Appealable	
C21-Customer Service	CAHPS		Not Appealable	
C22-Rating of Health Care Quality	CAHPS		Not Appealable	
C23-Rating of Health Plan	CAHPS		Not Appealable	
C24-Care Coordination	CAHPS		Not Appealable	
C25-Complaints about the Health Plan	CTM		Not Appealable	
C26-Members Choosing to Leave the Plan	MBDSS		Not Appealable	
C27-Health Plan Quality Improvement	Star Ratings		Not Appealable	
C28-Plan Makes Timely Decisions about Appeals	IRE			
C29-Reviewing Appeals Decisions	IRE			
C30-Call Center – Foreign Language Interpreter and TTY Availability	Call Center		X	We beleive incorrect data was used in the calculation for this measure given that one of the foreign language interpreter availability calls (C0600900) is incorrectly included in our results based on a technical issue associated with the non-standard manner in which the CMS caller asked the standard question. Please see the additional comments section below for the explanation.

Attachment A

Part D Measures	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
D01-Call Center – Foreign Language Interpreter and TTY Availability	Call Center			
D02-Complaints about the Drug Plan	CTM	Not Applicable	Not Applicable	Not appealable, use Part C measure C26 above.
D03-Members Choosing to Leave the Plan	MBDSS	Not Applicable	Not Applicable	Not appealable, use Part C measure C26 above.
D04-Drug Plan Quality Improvement	Star Ratings		Not Appealable	
D05-Rating of Drug Plan	CAHPS		Not Appealable	
D06-Getting Needed Prescription Drugs	CAHPS		Not Appealable	
D07-MPF Price Accuracy	PDE, MPF Pricing		Not Appealable	
D08-Medication Adherence for Diabetes Medications	PDE		Not Appealable	
D09-Medication Adherence for Hypertension (RAS antagonists)	PDE		Not Appealable	
D10-Medication Adherence for Cholesterol (Statins)	PDE		Not Appealable	
D11-MTM Program Completion Rate for CMR	Part D Plan Reporting		Not Appealable	
D12-Statin Use in Persons with Diabetes (SUPD)	PDE data		Not Appealable	

Additional Comments (Please provide any additional information relevant to your request)

Request for Informal Hearing related to SCAN Health Plan H5245 for Measure C30 – Call Center – Foreign Language Interpreter and TTY Availability based on incorrect data set used to calculate star rating that included call #C0600900 received 2/9/23.

We incorporate by reference and renew each and every one of our prior objections stated in our Request for Reconsideration for Measure C30 (attached hereto) based on the incorrect data set used to calculate SCAN's Star Rating that included call #C0600900 received by SCAN Health on 2/9/23. As detailed in our prior Request for Reconsideration, for call C0600900, there was a technical issue caused by the CMS caller that ultimately caused the call to exceed the 8 minute threshold: the CMS caller did not ask the question clearly, including multiple stumbles, speaking unusually slowly, and stating the plan name in a non-standard manner such that the interpreter had trouble understanding, requiring further clarification, and creating significant and unnecessary delay. Unfortunately, CMS's Reconsideration Decision ("Technical Report for SCAN Health Plan H5425") fails to meaningfully address the critical problems detailed in our Request for Reconsideration. We renew those same objections, as further detailed herein.

First: At Page 4 in the Reconsideration Decision, CMS states that "SCAN requests that call C0600900 be reclassified as a successful call in their results. This would adjust their score for measure C30 from 95% (4 stars) to 97% (5 stars)." To be clear: We requested, and now request again, that the call be either counted as a successful ("completed") call OR excluded from the C30 Star Rating measure. Either approach would result in SCAN Health's measure Star Rating increasing from 4 to 5 stars, and its overall Star Rating increasing to 4 Stars. This would result in SCAN qualifying for a quality bonus payment, as CMS rewards Medicare Advantage plans rated "4 stars or higher" with a quality bonus payment. See, e.g., 42 U.S.C. § 1396w-23(o)(1), (3)(A)(i).

Second: SCAN previously argued that the result of the call C0600900 was impacted by how the caller asked the question, which was not consistent with CMS's standard protocol, causing confusion on the part of the interpreter; the caller's speech resulted in the question needing to be repeated, and thus led to the call exceeding the time limit. The Reconsideration Decision states that CMS "disagree[s] with [SCAN's] assertion that the caller deviated from the standard protocol," and includes a table (at 5-6) purporting to document the translation of the secret shopper's statements. Line 4 and 5 of the table include the following:

"4. Exactly what the interviewer actually asked in French: Bonjour. Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de Village Health HMO POS D-SNP? 5. Exactly what the interviewer actually asked translated to English: Hello. Are you the right person to answer questions about health benefits of Village Health HMO POS D-SNP?"

But what is listed in line 4 of the table is not "exactly what the interviewer asked in French." CMS ignores the manner in which the question was delivered. SCAN outlined in its original request for reconsideration "exactly what the interviewer actually asked in French," with the secret shopper restarting the question and many long pauses, which caused the confusion for the interpreter and caused the need for the question to be repeated, which added over 34 seconds of time to the call and caused it to exceed the time limit. We encourage the reviewer to listen to the actual call to see why the description above does not appropriately represent the nature of the question:

French: Bonjour. "Êtes-vous la per……Êtes-vous la personne adéquate pour répondre aux questions concernant les avantages médicaux….de…uh…Village Health…..H-M-O……P-O-S…. C…..S-N-P?"

It took 25 seconds for the CMS caller to complete the question, because of the stumble, the need to start over, and the long pauses. The total elapsed time for the CMS caller to say "HMO POS CSNP" was 11 seconds. CMS claims in its Reconsideration Decision that "CMS callers are trained to ask questions in a conversational way" – but the way the CMS caller asked the question with the long pauses was not conversational at all. Thus, the interpreter was confused by the caller's slow reading of the individual letters in the plan name, and it was not clear that the caller was speaking the name of the plan. After the interpreter asks for the latter part of the question to be repeated, the CMS caller even goes so far as to clarify that it's the name of the plan ("the nom de plan") before she repeats it again. It is indisputable that the manner in which the question was asked caused confusion. Without that secret shopper's delay caused by the non-standard manner in which the question was asked, the call would have been completed within the 8-minute time limit, even with the amount of time it took to get the interpreter on the line.

Third: In our Request for Reconsideration, we included a recording of another French call (C1201277 that we received on 3/24/2023, attached hereto) where the exact same question was asked with the same plan name, and the CMS caller did ask the question in a conversational way without long pauses. The question was asked in 17 seconds (32% less time) and the plan name was very clear, and the interpreter had no issue understanding the question and did not need to ask for it to be repeated. CMS claims in the denial justification that "CMS asked the same question on both calls, and any difference in the way they were stated is down to the individual caller." But CMS also argues that "CMS callers are trained to ask the question in a conversational way." The way in which the challenged CMS caller asked the question was non-standard and caused confusion for the interpreter that led to the delay that caused the call to exceed the time limit. The Reconsideration Decision fails to provide any non-arbitrary rationale for its disparate treatment of call C0600900 and C1201277, with CMS stating (at 7) that any "differences in the way they [the questions] were stated is down to the individual caller, just like a non-test call would be, which is what CMS is testing." But that is exactly the point: CMS cannot provide any non-arbitrary justification for why SCAN Health should be penalized based on "differences in the way they [the questions] were stated [by] the individual caller." Indeed, CMS has taken the position elsewhere that it would not penalize Medicare Advantage plans for delays and confusion introduced even by interpreters in answering questions, as CMS "wouldn't hold that against you" and would not "count against you." 2016 CMS Call Center Monitoring Q&A at 3, https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting

Fourth: CMS's Reconsideration Decision also references that "SCAN's argument ignores the fact that it took over six and a half minutes for the interpreter to join the call to begin with." This is not an accurate representation of SCAN's argument at all. SCAN fully understands that it took that 6 minute and 35 seconds to get an interpreter on the line. SCAN would ask one simple question of the informal hearing reviewer:

Is 1 minute and 25 seconds enough time to complete the cycle of the CMS caller asking the standard question and getting the appropriate response from the customer service representative?

In its Reconsideration Decision, CMS ignores the fact that it is completely possible, and typical, to still have a successful call even in such a scenario, and CMS irrationally takes the position that if there is anything else irregular or inappropriate about the call, that the cause of the call failure is solely attributable to the time it took to get the interpreter on the line. That is not a fair and reasonable position – 1 minute and 25 seconds is more than enough time for the cycle to be completed when the standard question is asked clearly and appropriately. The reference call that we provided, C1201277, took 41 seconds to complete that cycle. The failed French call, C0600900, took 86 seconds to complete the cycle – 45 seconds longer than in call C1201277. Variations in individual callers should not result in it taking twice as much time to complete the cycle. This was not a normal variation in a conversational way of asking the standard question. 1 minute and 25 seconds is clearly sufficient to respond to a properly posed question, had the CMS caller posed one.

Fifth: In the Reconsideration Decision, CMS also includes 2023 statistics about the number of French calls to all plans, as well as to SCAN specifically, and claims that CMS asks the same question on all calls. That argument is not relevant to our reconsideration request - SCAN is not contending that CMS asks different questions on each call. SCAN is contending that the manner in which the CMS caller asked the question for the specific call in question was non-standard, given the stumbling and the long pauses, and inconsistent with the secret shopper's clearer manner of speech on call C1201277. The manner in which the question was asked caused the confusion for the interpreter that led to the delay that caused the call to exceed the time limit.

CMS goes on to argue in its denial justification that "call C0600900 is the only French language call that has been questioned for this year's study around the issue of how the introductory question was asked." That argument is also not relevant to SCAN's argument presented in our reconsideration. We are not questioning all other French calls. We are simply contending that for call C0600900, the question was asked in a non-standard manner that caused confusion for the interpreter, which led to the delay that cause the call to exceed the time limit.

In summary: As stated in our Request for Reconsideration, for call C0600900, the CMS caller's phrasing of the question and the way it was asked, including the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. The non-standard manner the question was asked resulted in an additional 34 seconds of time given the need to repeat the question. Without that 34-second delay caused by the non-standard manner in which the question was asked, the call would have been completed within the 8-minute time limit, even with the amount of time it took to get the interpreter on the line. That is why the call should either be deemed a successful call, or at a minimum, excluded from the sample for this star measure.

Additionally: The Reconsideration Decision asserts (at 2) that measure C30 is used to "ensure compliance with regulatory requirements, found at 42 C.F.R. §§ 422.111(h)." But the regulation upon which CMS relies states that "interpreters must be available for 80 percent of incoming calls requiring an interpreter within 8 minutes of reaching the customer service representative." Here, SCAN Health did have an interpreter "available" within 8 minutes of the caller reaching the customer service representative. The interpreter introduced himself at 6 minutes 35 seconds, and spent the remaining time in an interactive dialogue with the caller to interpret her question. "Available" simply means an interpreter is "present or ready for immediate use." Available, Merriam-Webster Dictionary (2024); see also United States v. Soybel, 13 F.4th 584, 595 (7th Cir. 2021) ("available" means "present or ready for immediate use"). That standard was clearly met here: The caller was "connected to an interpreter within 8 minutes," i.e., at 6:35. 86 Fed. Reg. 6007, 6007-08 (2021). Here, there is an arbitrary misalignment between CMS's stated goal in its regulation (to ensure that an interpreter is available, i.e. connected, within 8 minutes) and the rationale for its Reconsideration Decision (requiring SCAN Health to complete answering a caller's question within 8 minutes).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1129 and form number CMS-10346 (Expires: 8/31/2024). The time required to complete this information collection is estimated to average 8 hours, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

We incorporate by reference and renew each and every one of our prior objections stated in our Request for Reconsideration for Measure C30 (attached hereto) based on the incorrect data set used to calculate SCAN's Star Rating that included call #C0600900 received by SCAN Health on 2/9/23. As detailed in our prior Request for Reconsideration, for call C0600900, there was a technical issue caused by the CMS caller that ultimately caused the call to exceed the 8 minute threshold: the CMS caller did not ask the question clearly, including multiple stumbles, speaking unusually slowly, and stating the plan name in a non-standard manner such that the interpreter had trouble understanding, requiring further clarification, and creating significant and unnecessary delay. Unfortunately, CMS's Reconsideration Decision ("Technical Report for SCAN Health Plan H5425") fails to meaningfully address the critical problems detailed in our Request for Reconsideration. We renew those same objections, as further detailed herein.

First: At Page 4 in the Reconsideration Decision, CMS states that "SCAN requests that call C0600900 be reclassified as a successful call in their results. This would adjust their score for measure C30 from 95% (4 stars) to 97% (5 stars)." To be clear: We requested, and now request again, that the call be either counted as a successful ("completed") call OR excluded from the C30 Star Rating measure. Either approach would result in SCAN Health's measure Star Rating increasing from 4 to 5 stars, and its overall Star Rating increasing to 4 Stars. This would result in SCAN qualifying for a quality bonus payment, as CMS rewards Medicare Advantage plans rated "4 stars or higher" with a quality bonus payment. *See, e.g.*, 42 U.S.C. § 1395w-23(o)(1), (3)(A)(i).

Second: SCAN previously argued that the result of the call C0600900 was impacted by how the caller asked the question, which was not consistent with CMS's standard protocol, causing confusion on the part of the interpreter; the caller's speech resulted in the question needing to be repeated, and thus led to the call exceeding the time limit. The Reconsideration Decision states that CMS "disagree[s] with [SCAN's] assertion that the caller deviated from the standard protocol," and includes a table (at 5-6) purporting to document the translation of the secret shopper's statements. Line 4 and 5 of the table include the following:

> *"4. Exactly what the interviewer actually asked in French: Bonjour. Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de Village Health HMO POS D-SNP? 5. Exactly what the interviewer actually asked translated to English: Hello. Are you the right person to answer questions about health benefits of Village Health HMO POS D-SNP?"*

But what is listed in line 4 of the table is not "exactly what the interviewer asked in French." CMS ignores the manner in which the question was delivered. SCAN outlined in its original request for reconsideration "exactly what the interviewer actually asked in French," with the secret shopper restarting the question and many long pauses, which caused the confusion for the interpreter and caused the need for the question to be repeated, which added over 34 seconds of time to the call and caused it to exceed the time limit. We encourage the reviewer to listen to the actual call to see why the description above does not appropriately represent the nature of the question:

French: Bonjour. "Êtes-vous la per…..…..Êtes-vous la personne adéquate pour répondre aux questions concernant les avantages médicaux…..de…uh….Village Health….. H-M-O…..…P-O-S…. C…..S-N-P?"

It took 25 seconds for the CMS caller to complete the question, because of the stumble, the need to start over, and the long pauses. The total elapsed time for the CMS caller to say "HMO POS CSNP" was 11 seconds. CMS claims in its Reconsideration Decision that "CMS callers are trained to ask questions in a conversational way" – but the way the CMS caller asked the question with the long pauses was not conversational at all. Thus, the interpreter was confused by the caller's slow reading of the individual letters in the plan name, and it was not clear that the caller was speaking the name of the plan. After the interpreter asks for the latter part of the question to be repeated, the CMS caller even goes so far as to clarify that it's the name of the plan ("the nom de plan") before she repeats it again. It is indisputable that the manner in which the question was asked caused confusion. Without that secret shopper's delay caused by the non-standard manner in which the question was asked, the call would have been completed within the 8-minute time limit, even with the amount of time it took to get the interpreter on the line.

Third: In our Request for Reconsideration, we included a recording of another French call (C1201277 that we received on 3/24/2023, attached hereto) where the exact same question was asked with the same plan name, and the CMS caller did ask the question in a conversational way without long pauses. The question was asked in 17 seconds (32% less time) and the plan name was very clear, and the interpreter had no issue understanding the question and did not need to ask for it to be repeated. CMS claims in the denial justification that "CMS asked the same question on both calls, and any difference in the way they were stated is down to the individual caller." But CMS also argues that "CMS callers are trained to ask the question in a conversational way." The way in which the challenged CMS caller asked the question was non-standard and caused confusion for the interpreter that led to the delay that caused the call to exceed the time limit. The Reconsideration Decision fails to provide any non-arbitrary rationale for its disparate treatment of call C0600900 and C1201277, with CMS stating (at 7) that any "differences in the way they [the questions] were stated is down to the individual caller, just like a non-test call would be, which is what CMS is testing." But that is exactly the point: CMS cannot provide any non-arbitrary justification for why SCAN Health should be penalized based on "differences in the way they [the questions] were stated [by] the individual caller." Indeed, CMS has taken the position elsewhere that it would not penalize Medicare Advantage plans for delays and confusion introduced even by interpreters in answering questions, as CMS "wouldn't hold that against you" and would not "count against you." 2016 CMS Call Center Monitoring Q&A at 3, https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting

Fourth: CMS's Reconsideration Decision also references that "SCAN's argument ignores the fact that it took over six and a half minutes for the interpreter to join the call to begin with." This is not an accurate representation of SCAN's argument at all. SCAN fully understands that it took that 6 minute and 35 seconds to get an interpreter on the line. SCAN would ask one simple question of the informal hearing reviewer:

Is 1 minute and 25 seconds enough time to complete the cycle of the CMS caller asking the standard question and getting the appropriate response from the customer service representative?

In its Reconsideration Decision, CMS ignores the fact that it is completely possible, and typical, to still have a successful call even in such a scenario, and CMS irrationally takes the position that if there is anything else irregular or inappropriate about the call, that the cause of the call failure is solely attributable to the time it took to get the interpreter on the line. That is not a fair and reasonable position – 1 minute and 25 seconds is more than enough time for the cycle to be completed when the standard question is asked clearly and appropriately. The reference call that we provided, C1201277, took 41 seconds to complete that cycle. The failed French call, C0600900, took 86 seconds to complete the cycle – 45 seconds longer than in call C1201277. Variations in individual callers should not result in it taking twice as much time to complete the cycle. This was not a normal variation in a conversational way of asking the standard question. 1 minute and 25 seconds is clearly sufficient to respond to a properly posed question, had the CMS caller posed one.

Fifth: In the Reconsideration Decision, CMS also includes 2023 statistics about the number of French calls to all plans, as well as to SCAN specifically, and claims that CMS asks the same question on all calls. That argument is not relevant to our reconsideration request - SCAN is not contending that CMS asks different questions on each call. SCAN is contending that the manner in which the CMS caller asked the question for the specific call in question was non-standard, given the stumbling and the long pauses, and inconsistent with the secret shopper's clearer manner of speech on call C1201277. The manner in which the question was asked caused the confusion for the interpreter that led to the delay that caused the call to exceed the time limit.

CMS goes on to argue in its denial justification that “call C0600900 is the only French language call that has been questioned for this year’s study around the issue of how the introductory question was asked.” That argument is also not relevant to SCAN’s argument presented in our reconsideration. We are not questioning all other French calls. We are simply contending that for call C0600900, the question was asked in a non-standard manner that caused confusion for the interpreter, which led to the delay that cause the call to exceed the time limit.

In summary: As stated in our Request for Reconsideration, for call C0600900, the CMS caller’s phrasing of the question and the way it was asked, including the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. The non-standard manner the question was asked resulted in an additional 34 seconds of time given the need to repeat the question. Without that 34-second delay caused by the non-standard manner in which the question was asked, the call would have been completed within the 8-minute time limit, even with the amount of time it took to get the interpreter on the line. That is why the call should either be deemed a successful call, or at a minimum, excluded from the sample for this star measure.

Additionally: The Reconsideration Decision asserts (at 2) that measure C30 is used to "ensure compliance with regulatory requirements, found at 42 C.F.R. §§ 422.111(h)." But the regulation upon which CMS relies states that "interpreters must be available for 80 percent of incoming calls requiring an interpreter within 8 minutes of reaching the customer service representative." Here, SCAN Health did have an interpreter "available" within 8 minutes of the caller reaching the customer service representative: The interpreter introduced himself at 6 minutes 35 seconds, and spent the remaining time in an interactive dialogue with the caller to interpret her question. "Available" simply means an interpreter is "present or ready for immediate use." Available, Meriam-Webster Dictionary (2024); see also United States v. Soybel, 13 F.4th 584, 595 (7th Cir. 2021) ("available" means "present or ready for immediate use"). That standard was clearly met here: The caller was "connected to an interpreter within 8 minutes," i.e., at 6:35. 86 Fed. Reg. 6007, 6007-08 (2021). Here, there is an arbitrary misalignment between CMS's stated goal in its regulation (to ensure that an interpreter is available, i.e. connected, within 8 minutes) and the rationale for its Reconsideration Decision (requiring SCAN Health to complete answering a caller's question within 8 minutes).

Filename: C0600900
Client: Latham & Watkins
Job ID: US1796158
Date: February 27, 2024
Transcript by TransPerfect

00:00:00.0
RECORDED VOICE 1: Thank you for calling SCAN Health Plan. In order to ensure the highest level of service, this call is recorded and/or monitored for quality and training purposes. You are not required to provide any health related information, unless used to determine enrolment eligibility. Interpreter services are available at no cost. TTY users dial 7-1-1. For English press 1. For other languages press 2.

00:00:33.2
Thank you for calling SCAN Health Plan. Your call is important to us. The call may be recorded and/or monitored for quality purposes. Please stay on the line and the next available representative will be with you shortly. If you would like to become a SCAN member, please stay on the line. If you are a SCAN member, please press 2. If you are a provider, please press 3.

[MUSIC]

00:01:08.5
RECORDED VOICE 2: Taking your medications as directed is one of the best ways to manage your health. If you take ongoing medications, ask for a three-month—

00:01:22.2
OPERATOR: Thanks for calling SCAN Health. This is Jesse. Who do I have the pleasure speaking with?

00:01:27.5
CALLER: Uhhh… French? I need French?

00:01:31.6
OPERATOR: Yes, of course. One moment please.

[MUSIC: 00:01:37 — 00:06:25]

00:06:28.6
OPERATOR: One moment please, I'm still trying to locate a translator.

[MUSIC: 00:6:52 — 00:08:05]

00:08:05.5
INTERPRETER: … the French Interpreter, everything you say will remain secret and confidential. How can I help you?

00:08:13.7
OPERATOR: I have someone on the line who speaks French. Please go ahead.

00:08:19.9

INTERPRETER: Hello. My name is [INDISCERNIBLE: 00:08:22]. I am your French interpreter. Everything you say is going to be private and confidential.

00:08:31.7
CALLER: Yes, good evening.

00:08:35.2
INTERPRETER: Good evening.

00:08:33.6
CALLER: Hello. I have, I have a question, uh… are you the per-- are you the right person to answer questions about the medical benefits of uh… Village Health HMO . . . -POS . . .C . . . -SNP?

00:09:04.3
INTERPRETER: Excuse me, ma'am. I missed that. The medical benefits of this village. Can you repeat it, please?

00:09:14.2
CALLER: Yes, that's the name of the plan. It's Village Health, then HMO . . .-POS . . .C- . . . SNP.

00:09:42.1
INTERPRETER: Are you the right person to answer questions about the plan Village plus HMO-POS C-SNP?

00:09:57.0
OPERATOR: Yes, of course. How may I assist you?

00:10:01.6
INTERPRETER: Of course. What can I do for you?

00:10:07.0
WOMAN: Thank you. This has been a test call for the Centers for Medicare and Medicaid Services. We have reached the time limit for this question. Have a good day.

00:10:16.7
OPERATOR: Thank you. You too. Thank you interpreter.

00:10:18.8
INTERPRETER: Interpreter 0629754 disconnecting. Thank you for using our service.

[00:10:29]

Call C1201277.
Latham & Watkins LLP
February 28, 2024
Transcript by TransPerfect

[00:00]

RECORDED VOICE 1: Thank you for calling Scan Health Plan. In order to ensure the highest level of service, this call is recorded and or monitored for quality and training purposes. You are not required to provide any health related information unless used to determine enrollment eligibility. Interpreter services are available at no cost. TTY users dial 701 for English press one for other languages. Press two. Thank you for calling Scan Health plan. Your call is important to us. The call may be recorded and or monitored for quality purposes. Please stay on the line and the next available representative will be with you shortly. If you would like to become a scan member, please stay on the line. If you are a scan member, please press two. If you are a provider, please press three.

[*MUSIC*]

[01:05] **RECORDED VOICE 1:** We're excited to announce that scan has been named one of the best Medicare Advantage plans in California for 2023 by us. News and world.

[01:24] **OPERATOR:** Thank you for calling Scan Health Plan. This is Tanya, who do I have the pleasure of speaking to this morning?

[01:28] **CALLER:** No, English French.

[01:31] **OPERATOR:** Of course, one moment please.

[*MUSIC*]

[03:37] **OPERATOR:** Ok Maryanne, we're both here, thank you.

[03:40] **INTERPRETER:** My name is Maryanne, I'm a translator, ID number 064487. She said: "Thank you for calling Scan Health. How can I help you?"

[03:53] **CALLER:** Hello. Are you the right person to answer questions about the medical benefits of Village Health HMO POS CSNP?

[04:16] **INTERPRETER:** Are you the right person to answer the medical advantage of [INDISCERNIBLE] Plan HMO POS CSNP.

[04:34] **OPERATOR:** Yes.

[04:38] **INTERPRETER:** Yes.

[04:41] **CALLER:** Ok.

[04:45] **CALLER:** Thank you for your time, this has been a test call on behalf of the center for Medicare and Medicaid Services, have a good day.

[04:52] **OPERATOR:** Thank you so much, both of you. Have a wonderful afternoon.

[05:00] **CALLER**: Thank you.

Call C1201277.
Latham & Watkins LLP
February 28, 2024
Transcript by TransPerfect

[05:01] **OPERATOR**: Thank you

Medicare 2024 Part C & D Star Ratings Technical Notes

Updated – 12/13/2023

Document Change Log

Previous Version	Description of Change	Revision Date
09/29/2023	Corrected reopening decision deadline in the data source description for C29 in Measure Details section.	11/08/2023
09/29/2023	Updated 2024 measure IDs for display measures in Attachment J.	11/08/2023

OMB Approved Data Sources

The data collected for the Part C & D Star Ratings come from a variety of different data sources approved under the following Office of Management and Budget (OMB) Paperwork Reduction Act numbers:

Data Source	OMB Number
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys	0938-0732
Health Outcomes Survey (HOS)	0938-0701
Healthcare Effectiveness Data and Information Set (HEDIS)	0938-1028
Part C Reporting Requirements	0938-1054
Part D Reporting Requirements	0938-0992
Data Validation of Part C/D Reporting Requirements data	0938-1115

Table of Contents

DOCUMENT CHANGE LOG I
OMB APPROVED DATA SOURCES I
INTRODUCTION 9
DIFFERENCES BETWEEN THE 2023 STAR RATINGS AND 2024 STAR RATINGS 9
HEALTH/DRUG ORGANIZATION TYPES INCLUDED IN THE STAR RATINGS 10
Table 1: Contract Year 2024 Organization Types Reported in the 2024 Star Ratings 11
THE STAR RATINGS FRAMEWORK 11
Figure 1: The Four Levels of Star Ratings 12
Table 2: 5-Star Scale 12
Table 3: Relation of 2024 Organization Types to Contract Types and Highest Rating in the 2024 Star Ratings 12
SOURCES OF THE STAR RATINGS MEASURE DATA 13
Figure 2: The Four Categories of Data Sources 13
IMPROVEMENT MEASURES 13
Table 4: Minimum Number of Measure Scores Required for an Improvement Measure Rating by Contract Type 14
CONTRACT ENROLLMENT DATA 14
HANDLING OF BIASED, ERRONEOUS, AND/OR NOT REPORTABLE (NR) DATA 14
DATA HANDLING OF MEASURES FOR CONTRACTS AFFECTED BY A MAJOR DISASTER 15
METHODOLOGY FOR ASSIGNING STARS TO THE PART C AND PART D MEASURES 17
A. Clustering 17
B. Relative Distribution and Significance Testing (CAHPS) 18
METHODOLOGY FOR CALCULATING STARS AT THE DOMAIN LEVEL 18
Table 5: Minimum Number of Rated Measures Required for a Domain Rating by Contract Type 19
SUMMARY AND OVERALL RATINGS: WEIGHTING OF MEASURES 19
METHODOLOGY FOR CALCULATING PART C AND PART D SUMMARY RATINGS 19
Table 6: Minimum Number of Rated Measures Required for Part C and Part D Ratings by Contract Type 20
METHODOLOGY FOR CALCULATING THE OVERALL MA-PD RATING 20
Table 7: Minimum Number of Rated Measures Required for an Overall Rating by Contract Type 21
COMPLETING THE SUMMARY AND OVERALL RATING CALCULATIONS 21
APPLYING THE IMPROVEMENT MEASURE(S) 21
APPLYING THE REWARD FACTOR 22
Table 8: Performance Summary Thresholds 23
Table 9: Variance Thresholds 23
CATEGORICAL ADJUSTMENT INDEX (CAI) 23
Table 10: Categorization of Contract's Members into LIS/DE Initial Groups for the Overall Rating 25
Table 11: Categorization of Contract's Members into Disability Quintiles for the Overall Rating 25
Table 12: Final Adjustment Categories and CAI Values for the Overall Rating 26
Table 13: Categorization of Contract's Members into LIS/DE Initial Groups for the Part C Summary 26
Table 14: Categorization of Contract's Members into Disability Quintiles for the Part C Summary 27
Table 15: Final Adjustment Categories and CAI Values for the Part C Summary 27
Table 16: Categorization of Contract's Members into LIS/DE Initial Groups for the MA-PD Part D Summary 27

Table 17: Categorization of Contract's Members into Disability Quintiles for the MA-PD Part D Summary 28
Table 18: Final Adjustment Categories and CAI Values for the MA-PD Part D Summary 28
Table 19: Categorization of Contract's Members into Quintiles of LIS/DE for the PDP Part D Summary 28
Table 20: Categorization of Contract's Members into Quintiles of Disability for the PDP Part D Summary 29
Table 21: Final Adjustment Categories and CAI Values for the PDP Part D Summary 29
CALCULATION PRECISION 29
ROUNDING RULES FOR MEASURE SCORES 30
ROUNDING RULES FOR SUMMARY AND OVERALL RATINGS 30
Table 22: Rounding Rules for Summary and Overall Ratings 30
METHODOLOGY FOR CALCULATING THE HIGH PERFORMING ICON 30
Figure 3: The High Performing Icon 31
METHODOLOGY FOR CALCULATING THE LOW PERFORMING ICON 31
Figure 4: The Low Performing Icon 31
Table 23: Example LPI Contracts 31
MERGERS, NOVATIONS, AND CONSOLIDATIONS 31
RELIABILITY REQUIREMENT FOR LOW-ENROLLMENT CONTRACTS 32
SPECIAL NEEDS PLAN (SNP) DATA 32
STAR RATINGS AND MARKETING 33
CONTACT INFORMATION 33
FRAMEWORK AND DEFINITIONS FOR THE DOMAIN AND MEASURE DETAILS SECTION 33
PART C DOMAIN AND MEASURE DETAILS 36
Domain: 1 - Staying Healthy: Screenings, Tests and Vaccines 36
Measure: C01 - Breast Cancer Screening 36
Measure: C02 - Colorectal Cancer Screening 38
Measure: C03 - Annual Flu Vaccine 39
Measure: C04 - Monitoring Physical Activity 41
Domain: 2 - Managing Chronic (Long Term) Conditions 43
Measure: C05 - Special Needs Plan (SNP) Care Management 43
Measure: C06 - Care for Older Adults – Medication Review 46
Measure: C07 - Care for Older Adults – Pain Assessment 47
Measure: C08 - Osteoporosis Management in Women who had a Fracture 48
Measure: C09 - Diabetes Care – Eye Exam 50
Measure: C10 - Diabetes Care – Blood Sugar Controlled 51
Measure: C11 - Controlling Blood Pressure 53
Measure: C12 - Reducing the Risk of Falling 55
Measure: C13 - Improving Bladder Control 57
Measure: C14 - Medication Reconciliation Post-Discharge 59
Measure: C15 - Plan All-Cause Readmissions 60
Measure: C16 - Statin Therapy for Patients with Cardiovascular Disease 61
Measure: C17 - Transitions of Care 63
Measure: C18 - Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions 65
Domain: 3 - Member Experience with Health Plan 67
Measure: C19 - Getting Needed Care 67
Measure: C20 - Getting Appointments and Care Quickly 68
Measure: C21 - Customer Service 69
Measure: C22 - Rating of Health Care Quality 70
Measure: C23 - Rating of Health Plan 72
Measure: C24 - Care Coordination 73
Domain: 4 - Member Complaints and Changes in the Health Plan's Performance 75

Measure: C25 - Complaints about the Health Plan 75
Measure: C26 - Members Choosing to Leave the Plan 76
Measure: C27 - Health Plan Quality Improvement 78
Domain: 5 - Health Plan Customer Service 80
Measure: C28 - Plan Makes Timely Decisions about Appeals 80
Measure: C29 - Reviewing Appeals Decisions 81
Measure: C30 - Call Center – Foreign Language Interpreter and TTY Availability 83
PART D DOMAIN AND MEASURE DETAILS 85
Domain: 1 - Drug Plan Customer Service 85
Measure: D01 - Call Center – Foreign Language Interpreter and TTY Availability 85
Domain: 2 - Member Complaints and Changes in the Drug Plan's Performance 87
Measure: D02 - Complaints about the Drug Plan 87
Measure: D03 - Members Choosing to Leave the Plan 88
Measure: D04 - Drug Plan Quality Improvement 90
Domain: 3 - Member Experience with the Drug Plan 92
Measure: D05 - Rating of Drug Plan 92
Measure: D06 - Getting Needed Prescription Drugs 93
Domain: 4 - Drug Safety and Accuracy of Drug Pricing 95
Measure: D07 - MPF Price Accuracy 95
Measure: D08 - Medication Adherence for Diabetes Medications 97
Measure: D09 - Medication Adherence for Hypertension (RAS antagonists) 100
Measure: D10 - Medication Adherence for Cholesterol (Statins) 103
Measure: D11 - MTM Program Completion Rate for CMR 105
Measure: D12 - Statin Use in Persons with Diabetes (SUPD) 108
ATTACHMENT A: CAHPS CASE-MIX ADJUSTMENT 111
CAHPS Case-Mix Adjustment 111
Table A-1: Coefficients of Part C Getting Needed Care (C19) CAHPS Measure Composite Items 112
Table A-2: Coefficients of Part C Getting Appointments and Care Quickly (C20) CAHPS Measure Composite Items 113
Table A-3: Coefficients of Part C Customer Service (C21) CAHPS Measure Composite Items 114
Table A-4: Coefficients of Part C Stand-alone CAHPS Measures 115
Table A-5: Coefficients of Part C Care Coordination (C24) CAHPS Measure Composite Items 116
Table A-6: Coefficients of Part D CAHPS Stand-alone Measures 117
Table A-7: Coefficients of Part D Getting Needed Prescription Drugs (D06) CAHPS Measure Composite Items 118
ATTACHMENT B: CALCULATING MEASURE DATA FOR THE SURVIVING CONTRACT OF A CONSOLIDATION 119
First Year Following a Consolidation 119
Table B-1: Enrollment Month Used in Calculating Measure Scores for the Surviving Contract of a Consolidation 119
Table B-2: Example of Calculating the Measure Score for the Surviving Contract of a Consolidation 119
Second Year Following a Consolidation 119
ATTACHMENT C: NATIONAL AVERAGES FOR PART C AND D MEASURES 120
Table C-1: National Averages for Part C Measures 120
Table C-2: National Averages for Part D Measures 121
ATTACHMENT D: PART C AND D DATA TIME FRAMES 122
Table D-1: Part C Measure Data Time Frames 122
Table D-2: Part D Measure Data Time Frames 123
ATTACHMENT E: SNP MEASURE SCORING METHODOLOGIES 124
1. Medicare Part C Reporting Requirements Measure (C05: SNP Care Management) 124
2. NCQA HEDIS Measures - (C06 – C07: Care for Older Adults) 124
Table E-1: Example Calculation Using Effectiveness of Care Rate 125
ATTACHMENT F: CALCULATING MEASURE C15: PLAN ALL-CAUSE READMISSIONS 126
Example: Calculating the final rate for Contract 1 126
ATTACHMENT G: WEIGHTS ASSIGNED TO INDIVIDUAL PERFORMANCE MEASURES 127

Table G-1: Part C Measure Weights 127
Table G-2: Part D Measure Weights 129

ATTACHMENT H: CALCULATION OF WEIGHTED STAR RATING AND VARIANCE ESTIMATES 130

ATTACHMENT I: CALCULATING THE IMPROVEMENT MEASURE AND THE MEASURES USED 131

Calculating the Improvement Measure 131

General Standard Error Formula 132

Improvement Change Score Standard Error Numerical Example 132

Standard Error Formulas (SEF) for Specific Measures 133

1. SEF for Measures: C01, C02, C04, C05, C08 – C14, C16, C26, C28 – C30, D01, D03, D08 – D12 133
2. SEF for Measures: C06, C07 133
3. SEF for Measures: C03, C19 – C24, and D05, D06 133
4. SEF for Measures C25, D02 134
5. SEF for Measure D07 135

Star Ratings Measures Used in the Improvement Measures 136

Table I-1: Part C Measures Used in the Improvement Measure 136

ATTACHMENT J: STAR RATINGS MEASURE HISTORY 138

Table J-1: Part C Measure History 138
Table J-2: Part D Measure History 143
Table J-3: Common Part C & Part D Measure History 147

ATTACHMENT K: INDIVIDUAL MEASURE STAR ASSIGNMENT PROCESS 148

Clustering Methodology Introduction 148

Figure K-1: Diagram showing gaps in data where cut points are assigned. 148

Example 1 – Clustering Methodology for a Higher is Better measure 148

Table K-1: Medication Adherence for Diabetes Medications cut points example: cut points are for illustrative purposes 149
Figure K-2: Diagram showing star assignment based cut points. 149

Example 2 – Clustering Methodology for a Lower is Better measure 149

Table K-2: Members Choosing to Leave the Plan cut points example: cut points are for illustrative purposes 149

Clustering Methodology Detail 150

1. Produce the individual measure distance matrix. 150
2. Create a tree of cluster assignments. 151
3. Select the final set of clusters from the tree of cluster assignments. 151
4. Final Thresholds 152

Determining Stars from Scores and Thresholds 152

Table K-3: 2024 Star Ratings Part C non-CAHPS Measure Mean Resampling Estimated Thresholds 153
Table K-4: 2024 Star Ratings Part D non-CAHPS Measure Mean Resampling Estimated Thresholds 154
Table K-5: 2024 Star Ratings Part C non-CAHPS Measure Tukey Outlier Cutoffs 155
Table K-6: 2024 Star Ratings Part D non-CAHPS Measure Tukey Outlier Cutoffs 156
Table K-7: 2023 Star Ratings Part C Mean Resampling and Tukey Outlier Deletion Non-CAHPS Measure Thresholds 157
Table K-8: 2023 Star Ratings Part D Mean Resampling and Tukey Outlier Deletion Non-CAHPS Measure Thresholds 158

Relative Distribution and Significance Testing (CAHPS) Methodology 158

Table K-9: CAHPS Star Assignment Rules 159
Table K-10: CAHPS Star Assignment Alternate Representation 160
Table K-11: CAHPS Measure 12% Reliability Cutoffs 160

ATTACHMENT L: MEDICATION ADHERENCE MEASURE CALCULATIONS 161

Proportion of Days Covered Calculation 161

Example 1: Non-Overlapping Fills of Two Different Drugs 161

Table L-1: No Adjustment 161

Example 2: Overlapping Fills of the Same Generic Ingredient across Single and Combination Products 161

Table L-2: Before Overlap Adjustment 162

Table L-3: After Overlap Adjustment 162
Example 3: Overlapping Fills of the Same and Different Target Drugs 162
Table L-4: Before Overlap Adjustment 162
Table L-5: After Overlap Adjustment 163
PDC Adjustment for Inpatient, and Skilled Nursing Facility Stays Examples 163
Calculating the PDC Adjustment for IP Stays and SNF Stays 163
Example 1: Gap in Coverage after IP Stay 164
Table L-6: Before Adjustment 164
Table L-7: After Adjustment 165
Example 2: Gap in Coverage before IP Stay 165
Table L-8: Before Adjustment 165
Table L-9: After Adjustment 165
Example 3: Gap in Coverage Before and After IP Stay 165
Table L-10: Before Adjustment 166
Table L-11: After Adjustment 166
Example 4: Gap in Coverage After IP Stay and Overlap with Subsequent Fill of the Same Drug Class 166
Table L-12: Before Adjustment 166
Table L-13: After Adjustment 167
ATTACHMENT M: METHODOLOGY FOR PRICE ACCURACY MEASURE 168
Contract Selection 168
MPF Composite Price Accuracy Score 168
Example of Accuracy Index Calculation 171
Table M-1: Example of Price Accuracy Index Calculation 172
PDE = PRESCRIPTION DRUG EVENT 172
MPF = MEDICARE PLAN FINDER 172
ATTACHMENT N: MTM CMR COMPLETION RATE MEASURE SCORING METHODOLOGIES 173
Medicare Part D Reporting Requirements Measure (D11: MTM CMR Completion Rate Measure) 173
ATTACHMENT O: METHODOLOGY FOR THE PUERTO RICO MODEL 175
Model 176
Example 177
ATTACHMENT P: IDENTIFICATION OF CONTRACTS AFFECTED BY DISASTERS 178
Operational Steps to Calculating Enrollment Impacted in Affected Contracts. 178
Table P-1: Section 1135 waivers issued in relation to the FEMA major disaster declarations 178
Table P-2: Individual Assistance counties in FEMA Major Disaster Declared States 179
Table P-3: Organization type service areas and necessary transformations 179
Table P-4: Major Disasters with associated enrollment months 180
Table P-5: How enrollment periods were combined for contracts experiencing multiple disasters 180
Example: 181
Table P-6: Example Contract HAAAA's Service Areas and Enrollment during Relevant Disasters 181
ATTACHMENT Q: MISSING DATA MESSAGES 183
Measure level messages 183
Table Q-1: Measure level missing data messages 183
Assignment rules for Part C measure messages 183
Assignment rules for Part D measure messages 187
Table Q-2: MTM CMR Reason(s) for Display Message conversion 189
Domain, Summary, and Overall level messages 189
Table Q-3: Domain, Summary, and Overall level missing data messages 189
Assignment rules for Part C & Part D domain rating level messages 189
Assignment rules for Part C & Part D summary rating level messages 189

Assignment rules for overall rating level messages **190**
Disenrollment Reasons messages **190**
Table Q-4: Disenrollment Reason missing data messages 190
ATTACHMENT R: GLOSSARY OF TERMS **191**
ATTACHMENT S: HEALTH PLAN MANAGEMENT SYSTEM MODULE REFERENCE **195**
HPMS Star Ratings Module **195**
1. Measure Data page 195
Table S-1: Measure Data page sample 195
Medicare Star Ratings Report Card Master Table 195
2. Measure Detail – CTM Summary page 196
Table S-2: Measure Detail – CTM Summary page fields 197
3. Measure Detail – Part C Appeals page 197
Table S-3: Measure Detail – Part C Appeals page fields 197
4. Measure Detail – SNP CM page 198
Table S-4: Measure Detail – SNP CM page fields 198
5. Measure Detail – HEDIS page 198
Table S-5: Measure Detail – HEDISpage fields 199
Table S-6: HEDIS 2022 Audit Designations and 2024 Star Ratings 199
6. Measure Detail – CTM page 199
Table S-7: Measure Detail – CTM page fields 200
7. Measure Detail – Disenrollment 200
Table S-8: Measure Detail – Disenrollment page fields 200
8. Measure Detail – DR (Disenrollment Reasons) 200
Table S-9: Measure Detail – Disenrollment Reasons page fields 201
9. Measure Detail – MTM page 201
Table S-10: Measure Detail – MTM page fields 201
10. Measure Detail – CAHPS page 202
Table S-11: Measure Detail – CAHPS page fields 202
11. Calculation Detail – MD 202
Table S-12: Calculation Detail – MD page fields 203
12. Calculation Detail – CAI 203
Table S-13: Measure Detail – CAI page fields 204
13. Measure Detail – HEDIS LE page 204
Table S-14: Measure Detail – HEDIS LE page fields 205
14. Measure Detail – C MD Results 205
Table S-15: Measure Detail – C MD Results 205
15. Measure Detail – D MD Results 205
Table S-16: Measure Detail – D MD Results 206
16. Measure Detail – C Improvement page 206
Table S-17: Part C Measure Improvement Results 206
17. Measure Detail – D Improvement page 206
Table S-18: Part D Measure Improvement Results 207
18. Measure Stars page 207
Table S-19: Measure Stars page sample 207
Medicare Star Ratings Report Card Master Table 207
19. Domain Stars page 207
Table S-20: Domain Star page sample 208
Medicare Star Ratings Report Card Master Table 208
20. Part C Summary Rating page 208
Table S-21: Part C Summary Rating page fields 208
21. Part D Summary Rating page 209
Table S-22: Part D Summary Rating View 209
22. Overall Rating page 209
Table S-23: Overall Rating View 210
23. Low Performing Contract List 210
Table S-24: Low Performing Contract List 211
24. High Performing Contract List 211

Table S-25: High Performing Contract List 211
25. Technical Notes link 211
26. Medication NDC List 212
27. Part C and Part D Example Measure Data 212

Introduction

CMS created the Part C & D Star Ratings to provide quality and performance information to Medicare beneficiaries to assist them in choosing their health and drug services during the annual fall open enrollment period. We refer to them as the '2024 Medicare Part C & D Star Ratings' because they are posted prior to the 2024 open enrollment period.

This document describes the methodology for creating the Part C & D Star Ratings displayed on the Medicare Plan Finder (MPF) at http://www.medicare.gov/ and posted on the CMS website at http://go.cms.gov/partcanddstarratings. A Glossary of Terms used in this document can be found in Attachment R.

The Star Ratings data are also displayed in the Health Plan Management System (HPMS). In HPMS, the data can be found by selecting: "Quality and Performance," then "Performance Metrics," then "Reports," then "Star Ratings and Display Measures," then "Star Ratings" for the report type, and "2024" for the report period. See Attachment S: Health Plan Management System Module Reference for descriptions of the HPMS pages.

The Star Ratings Program is consistent with the "Meaningful Measures" framework which focuses on measures related to person-centered care, equity, safety, affordability and efficiency, chronic conditions, wellness and prevention, seamless care coordination, and behavioral health. With Meaningful Measures 2.0, CMS plans to better address health care priorities and gaps, emphasize digital quality measurement, and promote patient perspectives of care. The Star Ratings include measures applying to the following five broad categories:

- Outcomes: Outcome measures reflect improvements in a beneficiary's health and are central to assessing quality of care.
- Intermediate outcomes: Intermediate outcome measures reflect actions taken which can assist in improving a beneficiary's health status. Diabetes Care – Blood Sugar Controlled is an example of an intermediate outcome measure where the related outcome of interest would be better health status for beneficiaries with diabetes.
- Patient experience: Patient experience measures reflect beneficiaries' perspectives of the care they received.
- Access: Access measures reflect processes and issues that could create barriers to receiving needed care. Plan Makes Timely Decisions about Appeals is an example of an access measure.
- Process: Process measures capture the health care services provided to beneficiaries which can assist in maintaining, monitoring, or improving their health status.

Differences between the 2023 Star Ratings and 2024 Star Ratings

There have been several changes between the 2023 Star Ratings and the 2024 Star Ratings. This section provides a synopsis of the notable differences; the reader should examine the entire document for full details about the 2024 Star Ratings. A table with the complete history of measures used in the Star Ratings can be found in Attachment J.

- Changes
    a. Tukey outer fence outlier deletion was added to the hierarchical clustering methodology that is used to set cut points for non-CAHPS measures.
    b. The disaster policy was modified to include data integrity issues in the definition of missing data, such that disaster-affected contracts with a data integrity issue on a given measure received the final measure rating from the current year.

c. The weight for the Part C Controlling Blood Pressure measure was increased to 3.
d. Re-specified Part C Plan All-Cause Readmissions measure moved into the 2024 Star Ratings as a new measure with a weight of 1 for the first year.
e. The Part C Transitions of Care measure was added to the 2024 Star Ratings with a weight of 1.
f. The Part C Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions measure was added to the 2024 Star Ratings with a weight of 1.

- Transitioned measures (Moved to the display page on the CMS website: http://go.cms.gov/partcanddstarratings)
  a. None
- Retired measures
  a. Part C measure – Diabetes Care – Kidney Disease Monitoring

Health/Drug Organization Types Included in the Star Ratings

All health and drug plan quality and performance measure data described in this document are reported at the contract/sponsor level. Table 1 lists the contract year 2024 organization types and whether they are included in the Part C and/or Part D Star Ratings.

Table 1: Contract Year 2024 Organization Types Reported in the 2024 Star Ratings

Organization Type	Technical Notes Abbreviation	Medicare Advantage (MA)	Can Offer SNPs	Part C Ratings	Part D Ratings
1876 Cost	1876 Cost	No	No	Yes	Yes (if drugs offered)
Demonstration (Medicare-Medicaid Plan) †	MMP	No	No	No	No
Employer/Union Only Direct Contract Local Coordinated Care Plan (CCP)	CCP	Yes	No	Yes	Yes
Employer/Union Only Direct Contract Prescription Drug Plan (PDP)	PDP	No	No	No	Yes
Employer/Union Only Direct Contract Private Fee-for-Service (PFFS)	PFFS	Yes	No	Yes	Yes (if drugs offered)
HCPP 1833 Cost	HCPP	No	No	No	No
Local Coordinated Care Plan (CCP)	CCP	Yes	Yes	Yes	Yes
Medical Savings Account (MSA)	MSA	Yes	No	Yes	No
National PACE	PACE	No	No	No	No
Medicare Prescription Drug Plan (PDP)	PDP	No	No	No	Yes
Private Fee-for-Service (PFFS)	PFFS	Yes	No	Yes	Yes (if drugs offered)
Regional Coordinated Care Plan (CCP)	CCP	Yes	Yes	Yes	Yes
Religious Fraternal Benefit Private Fee-for-Service (RFB PFFS)	PFFS	Yes	No	Yes	Yes (if drugs offered)

† Note: The measure scores from these organizations are displayed in HPMS only during the first plan preview. Data from these organizations are not used in calculating the Part C & D Star Ratings.

The Star Ratings Framework

The Star Ratings are based on health and drug plan quality and performance measures. Each measure is reported in two ways:

Score: A score is either a numeric value or an assigned 'missing data' message.

Star: The measure numeric value is converted to a Star Rating.

The measure Star Ratings are combined into three groups and each group is assigned 1 to 5 stars. The three groups are:

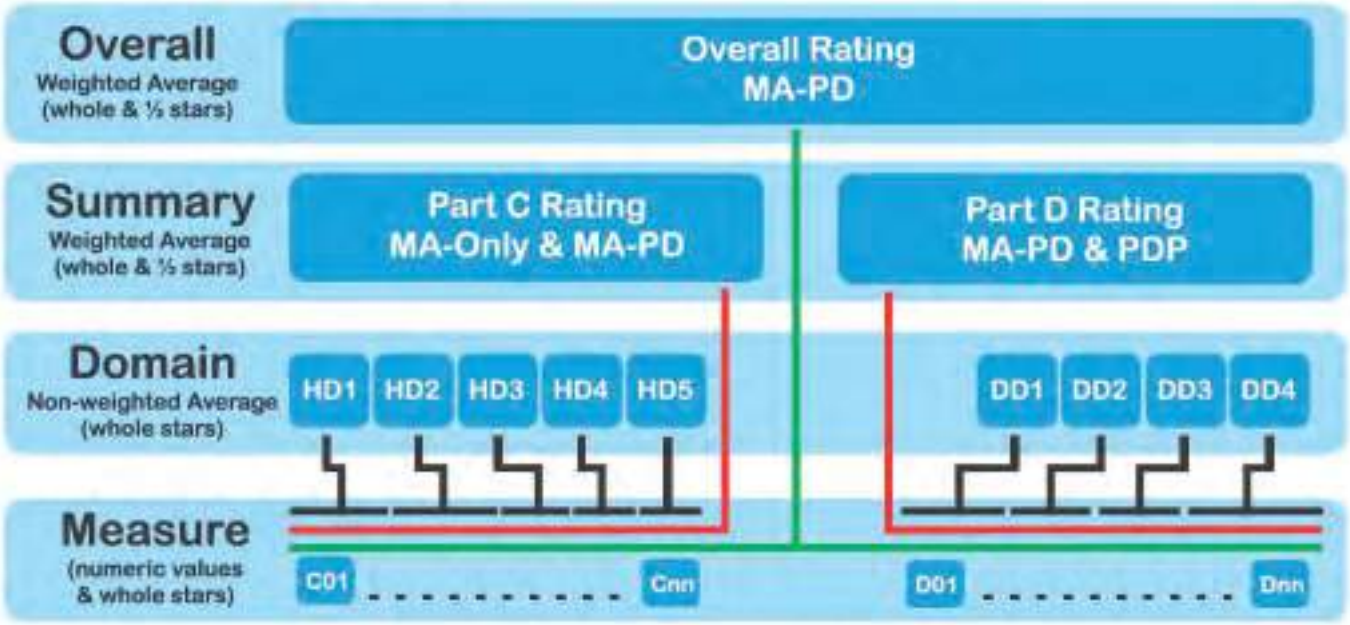
Domain: Domains group together measures of similar services. Star Ratings for domains are calculated using the non-weighted average Star Ratings of the included measures.

Summary: Part C measures are grouped to calculate a Part C Rating; Part D measures are grouped to calculate a Part D Rating. Summary ratings are calculated from the weighted average Star Ratings of the included measures.

Overall: For MA-PDs, all unique Part C and Part D measures are grouped to create an overall rating. The overall rating is calculated from the weighted average Star Ratings of the included measures.

Figure 1 shows the four levels of Star Ratings that are calculated and reported publicly.

Figure 1: The Four Levels of Star Ratings



The whole star scale used at the measure and domain levels is shown in Table 2.

Table 2: 5-Star Scale

Numeric	Graphic	Description
5	★★★★★	Excellent
4	★★★★	Above Average
3	★★★	Average
2	★★	Below Average
1	★	Poor

To allow for more variation across contracts, CMS assigns half stars to the summary and overall ratings.
As different organization types offer different benefits, CMS classifies contracts into three contract types. The highest level Star Rating differs among the contract types because the set of required measures differs by contract type. Table 3 clarifies how CMS classifies contracts for purposes of the Star Ratings and indicates the highest rating available for each organization type.

Table 3: Relation of 2024 Organization Types to Contract Types and Highest Rating in the 2024 Star Ratings

Organization Type	1876 Cost (no drugs) †	1876 Cost (offers drugs) †	CCP	MSA	PDP	PFFS (no drugs)	PFFS (offers drugs)
Rated As	MA-Only	MA-PD	MA-PD	MA-Only	PDP	MA-Only	MA-PD
Highest Rating	Part C rating	Overall Rating	Overall Rating	Part C Rating	Part D Rating	Part C Rating	Overall Rating

† Note: While 1876 contracts are not MA contracts, for the purposes of determining the highest rating they are considered to be rated as either "MA-only" or "MA-PD" depending on whether they offer drugs.

Sources of the Star Ratings Measure Data

The 2024 Star Ratings include a maximum of 9 domains comprised of a maximum of 42 measures.

- MA-Only contracts are measured on 5 domains with a maximum of 30 measures.
- PDPs are measured on 4 domains with a maximum of 12 measures.
- MA-PD contracts are measured on all 9 domains with a maximum of 42 measures, 40 of which are unique measures. Two of the measures are shown in both Part C and Part D so that the results for a MA-PD contract can be compared to an MA-Only contract or a PDP contract. Only one instance of those two measures is used in calculating the overall rating. The two duplicated measures are Complaints about the Health/Drug Plan (CTM) and Members Choosing to Leave the Plan (MCLP).

For a health and/or drug plan to be included in the Part C & D Star Ratings, they must have an active contract with CMS to provide health and/or drug services to Medicare beneficiaries. All of the data used to rate the plans are collected through normal contractual requirements or directly from CMS systems. Information about Medicare Advantage contracting can be found at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html and Prescription Drug Coverage contracting at: https://www.cms.gov/Medicare/Prescription-Drug-coverage/PrescriptionDrugCovContra/index.html. The data used in the Star Ratings come from four categories of data sources which are shown in Figure 2.

Figure 2: The Four Categories of Data Sources

Improvement Measures

Unlike the other Star Rating measures which are derived from data sources external to the Star Ratings, the Part C and Part D improvement measures are derived through comparisons of a contract's current and prior year measure scores. For a measure to be included in the improvement calculation the measure must not have had a significant specification change during those years. The Part C improvement measure includes only Part C measure scores and the Part D improvement measure includes only Part D measure scores. The measures and formulas for the improvement measure calculations are found in Attachment I. If a scaled reduction is applied to the Part C appeals measure in the previous year, the associated appeals measures will not be included in the Health Plan Quality Improvement measure.

The numeric results of these calculations are not publicly posted; only the measure ratings are reported publicly. Further, to receive a Star Rating in the improvement measures, a contract must have measure scores for both years in at least half of the required measures used to calculate the Part C improvement or Part D improvement measures. Improvement scores are not calculated for reconfigured regional contracts until data is available for the reconfigured structure from both years. Improvement scores are not calculated for consolidated contracts in their first year. Table 4 presents the minimum number of measure scores required to receive a rating for the improvement measures.

Table 4: Minimum Number of Measure Scores Required for an Improvement Measure Rating by Contract Type

Part	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
C	11 of 21	12 of 23	13 of 26	7 of 14	11 of 22	N/A	12 of 23
D	5 of 10*	6of 11	6 of 11	5 of 9	N/A	6 of 11	6 of 11*

* Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.

For a detailed description of all Part C and Part D measures, see the section entitled "Framework and Definitions for the Domain and Measure Details."

Contract Enrollment Data

The enrollment data used in the Part C and Part D "Complaints about the Health/Drug Plan" measures are pulled from HPMS. These enrollment files represent the number of enrolled beneficiaries the contract was paid for in a specific month. For these measures, twelve months of enrollment files are pulled (January 2022 through December 2022) and the average enrollment across those months is used in the calculations.

Enrollment data are also used when combining the plan-level data into contract-level data in the two Part C "Care for Older Adults" Healthcare Effectiveness Data and Information Set (HEDIS) measures. ("The Care for Older Adults – Functional Status Assessment" measure is currently on the display page). When there is a reported rate, the eligible population in the plan benefit package (PBP) submitted with the HEDIS data is used. If the audit designation for the PBP level HEDIS data is set to "Not Reported" (NR) or "Biased Rate" (BR) by the auditor (see following section), there is no value in the eligible population field. In these instances, twelve months of PBP-level enrollment files are pulled (January 2022 through December 2022), and the average enrollment in the plan across those months is used in calculating the combined rate.

Handling of Biased, Erroneous, and/or Not Reportable (NR) Data

The data used for CMS's Star Ratings must be accurate and reliable. CMS has identified issues with some contracts' data and has taken steps to protect the integrity of the data. For any measure scores CMS identifies to be based on inaccurate or biased data, CMS's policy is to reduce a contract's measure rating to 1 star and set the measure score to "CMS identified issues with this plan's data."

Inaccurate or biased data result from the mishandling of data, inappropriate processing, or implementation of incorrect practices. Examples include, but are not limited to: a contract's failure to adhere to HEDIS, Health Outcomes Survey (HOS), or CAHPS reporting requirements; a contract's failure to adhere to Medicare Plan Finder data requirements; a contract's errors in processing organization determinations and appeals; compliance actions taken against the contract due to errors in operational areas that impact the data reported or processed for specific measures; or a contract's failure to pass validation of the data reported for specific measures. For HEDIS data, CMS uses the audit designation information assigned by the HEDIS auditor. An audit designation of 'NR' (Not reported) is assigned when the contract chooses not to report the measure. An audit designation of 'BR' (Biased rate) is assigned when the individual measure score is materially biased (e.g., the auditor informs the contract the data cannot be reported to the National Committee for Quality Assurance (NCQA) or to CMS). When either a 'BR' or 'NR' designation is assigned to a HEDIS measure audit designation, the contract receives 1 star for the measure and the measure score is set to "CMS identified issues with this plan's data." In addition, CMS reduces contracts' HEDIS measure ratings to 1 star if the patient-level data files are not successfully submitted and validated by the submission deadline. Also, if the HEDIS summary-level data value varies substantially from the value in the patient-level data, the measure is reduced to a rating of 1 star. If an approved CAHPS or HOS vendor does not submit a contract's CAHPS or HOS data by

the data submission deadline, the contract automatically receives a rating of 1 star for the CAHPS or HOS measures and the measure scores are set to "CMS identified issues with this plan's data."

Data Handling of Measures for Contracts Affected by a Major Disaster

CMS has a policy for making adjustments in the Star Ratings to take into account major disasters. That policy was described in the 2024 Rate Announcement (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.) This is also codified in regulation at §422.166(i) and §423.186(i).

This section describes how the policy is implemented for measures from each of the different data sources in the 2024 Star Ratings. The methodology used by CMS to identify the major disaster geographic areas, determine which contracts were affected, and how much of their geographic service area and percent of enrollment resided in an affected area can be found in Attachment P.

The disaster policy specified two distinct thresholds of "25% or more" and "60% or more" of the contract's membership at the time of the disaster resided in a FEMA-designated Individual Assistance area. CMS calculated the percentage of enrollment affected for every contract being rated and applied the following rules to the data from those contracts that meet or exceed either of the two thresholds.

- CAHPS adjustments:
  - All contracts were required to administer the 2023 CAHPS survey unless the contract requested and CMS approved an exemption.
  - All affected contracts with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster receive the higher of the 2023 or the 2024 Star Rating (and corresponding measure score) for each CAHPS measure (including the annual flu vaccine measure).
  - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated individual Assistance areas that were affected by disasters than began in 2022 were also affected by disasters in 2021. These doubly-affected contracts receive the higher of the 2024 Star Rating or what the 2023 Star Ratings would have been in the absence of any adjustments that took into account the effects of the 2021 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected). For example, if doubly-affected contract reverted back to the 2022 Star Rating on a given measure in the 2023 Star Ratings, the 2022 Star Rating is *not* used in determining the 2024 Star Rating. Rather the 2024 Star Rating is compared to what the 2023 Star Rating would have been absent any disaster adjustments.
- HEDIS-HOS adjustments:
  - The HEDIS-HOS data used in the 2024 Star Ratings are adjusted for 2021 disasters (see Attachment P of the 2023 Star Ratings Technical Notes for the identification of contracts affected by 2021 disasters).
  - All affected contracts (i.e., contracts affected by 2021 disasters) with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster received the higher of the 2023 or the 2024 Star Rating (and corresponding measure score) for each HEDIS-HOS measure.
  - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas affected by disasters that began in 2021 were also affected by disasters in 2020. These doubly-affected contracts receive the higher of the 2024 Star Rating or what the 2023 Star Rating would have been in the absence of any adjustments that took into account the effects of the

2020 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected).

- HEDIS adjustments:
  - All contracts were required to report HEDIS 2023 unless the contract requested and CMS approved an exemption. Contracts were able to work with NCQA to adjust samples if necessary.
  - Contracts with 25% or more affected members received the higher of the 2023 or 2024 Star Rating (and corresponding measure scores) for each HEDIS measure.
  - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas affected by disasters that began in 2022 were also affected by disasters in 2021. These doubly-affected contracts receive the higher of the 2024 Star Rating or what the 2023 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2021 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected).
- Part C and D Call Center:
  - For all contracts, no adjustments were made.
- New measures:
  - Contracts with 25% or more affected members have a hold harmless provision applied which compares the result of a contract's overall rating "with" and "without" including the new Transitions of Care and Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions measures and respecified Plan All-Cause Readmissions measure. If the "with" result is lower than the "without" result, then we use the "without" result as the final highest level rating.
  - A similar hold harmless provision is applied for the Part C summary ratings. If a contract has 25% or more affected members, the Part C summary rating is calculated "with" and "without" the new Transitions of Care and Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions measures and respecified Plan All-Cause Readmissions measure, and if the "with" result is lower than the "without" result, then we use the "without" result for the final summary rating.
- All other measures:
  - Contracts with 25% or more affected members receive the higher of the 2023 or 2024 measure stars (and corresponding measure scores).
  - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas affected by disasters that began in 2022 were also affected by disasters in 2021. These doubly-affected contracts receive the higher of the 2024 Star Rating or what the 2023 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2021 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected).
- All adjustments:
  - For all adjustments, if the Star Rating is the same in both years, the Star Rating and the measure score from the most recent year are used.
- Improvement measures:
  - For affected contracts that reverted back to the data underlying the previous year's Star Rating for a particular measure for either 2023 or 2024 Star Ratings, that measure is excluded from both the

count of measures (used to determine whether the contract has at least half of the measures needed to calculate the relevant improvement measure) and the improvement measures calculation. Affected contracts do not have the option of reverting to the prior year's improvement rating.

- Affected contracts with missing data:
  - If an affected contract has missing data in either the current or previous year (e.g., because of a data integrity issue, it is too new, or it is too small), the final measure rating comes from the current year. Missing data includes data where there is a data integrity issue.
- Reward factor:
  - Affected contracts with 60% or more of their enrollees impacted by a 2022 disaster are excluded from the determination of the performance summary and variance thresholds for the Reward Factor.
- Cut points:
  - Clustering Methodology: For all measures that use the clustering methodology for cut point generation, the measure scores for contracts with 60% or more of their enrollment affected by a disaster are excluded from creating those cut points.

Methodology for Assigning Stars to the Part C and Part D Measures

CMS assigns stars for each numeric measure score by applying one of two methods: clustering, or relative distribution and significance testing. Each method is described below. Attachment K explains the clustering and relative distribution and significance testing (used for CAHPS measures) methods in greater detail.

The *Cut Point Trend* document is posted at http://go.cms.gov/partcanddstarratings and is updated after each rating cycle is released.

A. Clustering

This method is applied to the majority of the Star Ratings measures, ranging from operational and process-based measures, to HEDIS and other clinical care measures. Using this method, the Star Rating for each measure is determined by applying a clustering algorithm to the measure's numeric value scores from all contracts. Conceptually, the clustering algorithm identifies the "gaps" among the scores and creates four cut points resulting in the creation of five levels (one for each Star Rating). The scores in the same Star Rating level are as similar as possible; the scores in different Star Rating levels are as different as possible. Star Rating levels 1 through 5 are assigned with 1 being the worst and 5 being the best.

Technically, the variance in measure scores is separated into within-cluster and between-cluster sum of squares components. The clusters reflect the groupings of numeric value scores that minimize the variance of scores within the clusters. The Star Ratings levels are assigned to the clusters that minimize the within-cluster sum of squares. The cut points for star assignments are derived from the range of measure scores per cluster, and the star levels associated with each cluster are determined by ordering the means of the clusters.

Tukey outlier deletion is used to determine the cut points for all non-CAHPS measures. Tukey outlier deletion involves removing Tukey outer fence outlier contract scores, those defined as measure-specific scores outside the bounds of 3.0 times the measure-specific interquartile range subtracted from the 1st quartile or added to the 3rd quartile. Outliers are removed prior to applying mean resampling within the hierarchical clustering algorithm.

Mean resampling is used to determine the cut points for all non-CAHPS measures. With mean resampling, measure-specific scores for the current year's Star Ratings are randomly separated into 10 equal-sized groups.

The hierarchal clustering algorithm is then applied 10 times, each time leaving one of the 10 groups out of the clustered data. The method results in 10 sets of measure-specific cut points. The mean for each 1 through 5 star level cut point is taken across the 10 sets for each measure to produce the final cut points.

Guardrails are used to cap the amount of increase or decrease in measure cut point values from one year to the next. Specifically, each 1 to 5 star level cut point is compared to the prior year's value and capped at an increase or decrease of at most 5 percentage points for measures having a 0 to 100 scale (absolute percentage cap) or at most 5 percent of the prior year's restricted score range for measures not having a 0 to 100 scale (restricted range cap). The final capped cut points after comparing each 1 through 5 star level cut point to the prior year's values are used for assigning measure stars.

B. Relative Distribution and Significance Testing (CAHPS)

This method is applied to determine valid star cut points for CAHPS measures. In order to account for the reliability of scores produced from the CAHPS survey, the method combines evaluating the relative percentile distribution with significance testing. For example, to obtain 5 stars, a contract's CAHPS measure score needs to be ranked at least at the 80th percentile and be statistically significantly higher than the national average CAHPS measure score, as well as either have not low reliability or have a measure score more than one standard error above the 80th percentile. To obtain 1 star, a contract's CAHPS measure score needs to be ranked below the 15th percentile and be statistically significantly lower than the national average CAHPS measure score, as well as either have not low reliability or have a measure score more than one standard error below the 15th percentile.

Methodology for Calculating Stars at the Domain Level

A domain rating is the average, unweighted mean, of the domain's measure stars. To receive a domain rating, a contract must meet or exceed the minimum number of rated measures required for the domain. The minimum number of rated measures required for a domain is determined based on whether the total number of measures in the domain for a contract type is odd or even:

- If the total number of measures that comprise the domain for a contract type is odd, divide the number of measures in the domain by two and round the quotient to the next whole number.
  - Example: If the total number of measures required in a domain for a contract type is 3, the value 3 is divided by 2. The quotient, in this case 1.5, is then rounded to the next whole number. To receive a domain rating, the contract must have a Star Rating for at least 2 of the 3 required measures.
- If the total number of measures that comprise the domain for a contract type is even, divide the number of measures in the domain by two and add one to the quotient.
  - Example: If the total number of measures required in a domain for a contract type is 6, the value 6 is divided by 2. In this example, 1 is then added to the quotient of 3. To receive a domain rating, the contract must have a Star Rating for at least 4 of the 6 required measures.

Table 5 details the minimum number of rated measures required for a domain rating by contract type.

Table 5: Minimum Number of Rated Measures Required for a Domain Rating by Contract Type

Part	Domain Name (Identifier)	1876 Cost †	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
C	Staying Healthy: Screenings, Tests and Vaccines (HD1)	3 of 4	3 of 4	3 of 4	2 of 2	3 of 4	N/A	3 of 4
C	Managing Chronic (Long Term) Conditions (HD2)	5 of 8	6 of 11	8 of 14	6 of 10	6 of 11	N/A	6 of 11
C	Member Experience with Health Plan (HD3)	4 of 6	4 of 6	4 of 6	N/A	4 of 6	N/A	4 of 6
C	Member Complaints and Changes in the Health Plan's Performance (HD4)	2 of 3	2 of 3	2 of 3	2 of 3	2 of 3	N/A	2 of 3
C	Health Plan Customer Service (HD5)	2 of 2	2 of 3	2 of 3	2 of 3	2 of 2	N/A	2 of 3
D	Drug Plan Customer Service (DD1)	N/A*	1 of 1	1 of 1	1 of 1	N/A	1 of 1	1 of 1*
D	Member Complaints and Changes in the Drug Plan's Performance (DD2)	2 of 3*	2 of 3	2 of 3	2 of 3	N/A	2 of 3	2 of 3*
D	Member Experience with the Drug Plan (DD3)	2 of 2*	2 of 2	2 of 2	N/A	N/A	2 of 2	2 of 2*
D	Drug Safety and Accuracy of Drug Pricing (DD4)	4 of 6*	4 of 6	4 of 6	4 of 6	N/A	4 of 6	4 of 6*

* Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.
† Note: 1876 Cost contracts that offer drug benefits and which do not submit data for the MPF measure must have a rating in 3 out of 5 Drug Safety and Accuracy of Drug Pricing (DD4) measures to receive a rating in that domain.

Summary and Overall Ratings: Weighting of Measures

The summary and overall ratings are calculated as weighted averages of the measure stars. For the 2024 Star Ratings, CMS assigns the highest weight to the improvement measures, followed by patient experience/complaints and access measures, then by outcome and intermediate outcome measures, and finally process measures. New measures included in the Star Ratings are given a weight of 1 for their first year of inclusion in the ratings; in subsequent years the weight associated with the measure weighting category is used. The weights assigned to each measure and their weighting category are shown in Attachment G.
In calculating the summary and overall ratings, a measure given a weight of 3 counts three times as much as a measure given a weight of 1. For any given contract, any measure without a rating is not included in the calculation. The first step in the calculation is to multiply each measure's weight by the measure's rating and sum these results. The second step is to divide this sum by the sum of the weights of the contract's rated measures. For the summary and overall ratings, half stars are assigned to allow for more variation across contracts.

Methodology for Calculating Part C and Part D Summary Ratings

The Part C and Part D summary ratings are calculated by taking a weighted average of the measure stars for Parts C and D, respectively. To receive a Part C and/or Part D summary rating, a contract must meet the minimum number of rated measures. The Parts C and D improvement measures are not included in the count of the minimum number of rated measures. The minimum number of rated measures required is determined as follows:

- If the total number of measures required for the organization type is odd, divide the number by two and round it to a whole number.
  - Example: if there are 13 required Part D measures for the organization, 13 / 2 = 6.5, when rounded the result is 7. The contract needs at least 7 measures with ratings out of the 13 total measures to receive a Part D summary rating.
- If the total number of measures required for the organization type is even, divide the number of measures by two.
  - Example: if there are 30 required Part C measures for the organization, 30 / 2 = 15. The contract needs at least 15 measures with ratings out of the 30 total measures to receive a Part C summary rating.

Table 6 shows the minimum number of rated measures required by each contract type to receive a summary rating.

Table 6: Minimum Number of Rated Measures Required for Part C and Part D Ratings by Contract Type

Rating	1876 Cost †	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Part C summary	11 of 22	13 of 26	15 of 29	9 of 17	13 of 25	N/A	13 of 26
Part D summary	5 of 10*	6 of 11	6 of 11	5 of 9	N/A	6 of 11	6 of 11*

* Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.
† Note: 1876 Cost contracts which do not submit data for the MPF measure must have ratings in 5 out of 9measures to receive a Part D rating.

Methodology for Calculating the Overall MA-PD Rating

For MA-PDs to receive an overall rating, the contract must have stars assigned to both the Part C and Part D summary ratings. If an MA-PD contract has only one of the two required summary ratings, the overall rating will show as "Not enough data available."

The overall rating for a MA-PD contract is calculated using a weighted average of the Part C and Part D measure stars. The weights assigned to each measure are shown in Attachment G.

There are a total of 42 measures (30 in Part C, 12 in Part D) in the 2024 Star Ratings. The following two measures are contained in both the Part C and D measure lists:

- Complaints about the Health/Drug Plan (CTM)
- Members Choosing to Leave the Plan (MCLP)

These measures share the same data source, so CMS includes only one instance of each of these two measures in the calculation of the overall rating. In addition, the Part C and D improvement measures are not included in the count for the minimum number of measures. Therefore, a total of 38 distinct measures are used in the calculation of the overall rating.

The minimum number of rated measures required for an overall MA-PD rating is determined using the same methodology as for the Part C and D summary ratings. Table 7 provides the minimum number of rated measures required for an overall Star Rating by contract type.

Table 7: Minimum Number of Rated Measures Required for an Overall Rating by Contract Type

Rating	1876 Cost †	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Overall Rating	15 of 30*	18 of 35	19 of 38	12 of 24	N/A	N/A	18 of 35*

* Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.
† Note: 1876 Cost contracts which do not submit data for the MPF measure must have ratings in 15 out of 29 measures to receive an overall rating.

Completing the Summary and Overall Rating Calculations

There are two adjustments made to the results of the summary and overall calculations described above. First, to reward consistently high performance, CMS utilizes both the mean and the variance of the measure stars to differentiate contracts for the summary and overall ratings. If a contract has both high and stable relative performance, a reward factor is added to the contract's ratings. Details about the reward factor can be found in the section entitled "Applying the Reward Factor." Second, the summary and overall ratings include a Categorical Adjustment Index (CAI) factor, which is added to or subtracted from a contract's summary and overall ratings. Details about the CAI can be found in the section entitled "Categorical Adjustment Index (CAI)."

The summary and overall rating calculations are run twice, once including the improvement measures and once without including the improvement measures. Based on a comparison of the results of these two calculations a decision is made as to whether the improvement measures are to be included in calculating a contract's final summary and overall ratings. Details about the application of the improvement measures can be found in the section entitled "Applying the Improvement Measure(s)."

Lastly, standard rounding rules are applied to convert the results of the final summary and overall ratings calculations into the publicly reported Star Ratings. Details about the rounding rules are presented in the section "Rounding Rules for Summary and Overall Ratings."

Applying the Improvement Measure(s)

The Part C Improvement Measure - Health Plan Quality Improvement (C27) and the Part D Improvement Measure - Drug Plan Quality Improvement (D04) were introduced earlier in this document in the section entitled "Improvement Measures." The measures and formulas for the improvement measures can be found in Attachment I. This section discusses whether and how to apply the improvement measures in calculating a contract's final summary and overall ratings.

Since high performing contracts have less room for improvement and consequently may have lower ratings on these measure(s), CMS has developed the following rules to not penalize contracts receiving 4 or more stars for their highest rating.

MA-PD Contracts

1. There are separate Part C and Part D improvement measures (C27 & D04) for MA-PD contracts.
   a. C27 is used in calculating the Part C summary rating of an MA-PD contract.
   b. D04 is used in calculating the Part D summary rating for an MA-PD contract.
   c. Both improvement measures will be used when calculating the overall rating in step 3.
2. Calculate the overall rating for MA-PD contracts without including either improvement measure.
3. Calculate the overall rating for MA-PD contracts with both improvement measures included.

4. If an MA-PD contract in step 2 has 4 or more stars, compare the two overall ratings. If the rating in step 3 is less than the value in step 2, use the overall rating from step 2; otherwise use the result from step 3.
5. For all other MA-PD contracts, use the overall rating from step 3.

MA-Only Contracts

1. Only the Part C improvement measure (C27) is used for MA-Only contracts.
2. Calculate the Part C summary rating for MA-Only contracts without including the improvement measure.
3. Calculate the Part C summary rating for MA-Only contracts with the Part C improvement measure.
4. If an MA-Only contract in step 2 has 4 or more stars, compare the two Part C summary ratings. If the rating in step 3 is less than the value in step 2, use the Part C summary rating from step 2; otherwise use the result from step 3.
5. For all other MA-Only contracts, use the Part C summary rating from step 3.

PDP Contracts

1. Only the Part D improvement measure (D04) is used for PDP contracts.
2. Calculate the Part D summary rating for PDP contracts without including the improvement measure.
3. Calculate the Part D summary rating for PDP contracts with the Part D improvement measure.
4. If a PDP contract in step 2 has 4 or more stars, compare the two Part D summary ratings. If the rating in step 3 is less than the value in step 2, use the Part D summary rating from step 2; otherwise use the result from step 3.
5. For all other PDP contracts, use the Part D summary rating from step 3.

Applying the Reward Factor

The following represents the steps taken to calculate and include the reward factor (r-Factor) in the Star Ratings summary and overall ratings. These calculations are performed both with and without the improvement measures included.

- Calculate the mean and the variance of all of the individual quality and performance measure stars at the contract level.
  - The mean is equal to the summary or overall rating before the reward factor is applied, which is calculated as described in the section entitled “Weighting of Measures.”
  - Using weights in the variance calculation accounts for the relative importance of measures in the reward factor calculation. To incorporate the weights shown in Attachment G into the variance calculation of the available individual performance measures for a given contract, the steps are as follows:
    - Subtract the summary or overall star from each performance measure’s star; square the results; and multiply each squared result by the corresponding individual performance measure weight.
    - Sum these results; call this ‘SUMWX.’
    - Set n equal to the number of individual performance measures available for the given contract.
    - Set W equal to the sum of the weights assigned to the n individual performance measures available for the given contract.
    - The weighted variance for the given contract is calculated as: $n * SUMWX / (W * (n-1))$. For the complete formula, please see Attachment H: Calculation of Weighted Star Rating and Variance Estimates.

- Categorize the variance into three categories:
  - low (0 to less than 30th percentile),
  - medium (greater than or equal to 30th to less than 70th percentile) and
  - high (greater than or equal to 70th percentile)
- Develop the reward factor as follows:
  - r-Factor = 0.4 (for contract w/ low variance & high mean (mean greater than or equal to 85th percentile))
  - r-Factor = 0.3 (for contract w/ medium variance & high mean (mean greater than or equal to 85th percentile))
  - r-Factor = 0.2 (for contract w/ low variance & relatively high mean (mean greater than or equal to 65th & less than 85th percentile))
  - r-Factor = 0.1 (for contract w/ medium variance & relatively high mean (mean greater than or equal to 65th & less than 85th percentile))
  - r-Factor = 0.0 (for all other contracts)

Tables 8 and 9 show the final threshold values used in reward factor calculations for the 2024 Star Ratings.

Table 8: Performance Summary Thresholds

Improvement	New Measures	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
With	With	65th	3.783333	3.702703	3.500000	3.700515
With	With	85th	4.121212	4.000000	3.857143	3.989691
With	Without	65th	3.810345	3.702703	3.500000	3.724138
With	Without	85th	4.169231	4.000000	3.857143	4.030928
Without	With	65th	3.848485	3.71875	3.631579	3.741573
Without	With	85th	4.169231	4.09375	3.937500	4.061111
Without	Without	65th	3.873016	3.71875	3.631579	3.759036
Without	Without	85th	4.225806	4.09375	3.937500	4.102564

Table 9: Variance Thresholds

Improvement	New Measures	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
With	With	30th	0.924375	0.860382	0.965801	0.972245
With	With	70th	1.482292	1.536357	1.548310	1.460744
With	Without	30th	0.894302	0.860382	0.965801	0.952953
With	Without	70th	1.486442	1.536357	1.548310	1.454437
Without	With	30th	0.876231	0.806738	0.751953	0.917753
Without	With	70th	1.485714	1.557540	1.419580	1.489974
Without	Without	30th	0.845782	0.806738	0.751953	0.893483
Without	Without	70th	1.496943	1.557540	1.419580	1.479720

Categorical Adjustment Index (CAI)

CMS has implemented an analytical adjustment called the Categorical Adjustment Index (CAI). The CAI is a factor that is added to or subtracted from a contract's Overall and/or Summary Star Ratings to adjust for the

average within-contract disparity in performance for Low Income Subsidy/Dual Eligible (LIS/DE) beneficiaries and disabled beneficiaries. The CAI value (factor) depends on the contract's percentage of beneficiaries with LIS/DE and the contract's percentage of beneficiaries with disabled status. These adjustments are performed both with and without the improvement measures included. The value of the CAI varies by the contract's percentage of beneficiaries with LIS/DE and disability status.

The CAI values use data collected for the 2023 Star Ratings. To calculate the CAI, case-mix adjustment is applied to all clinical Star Rating measure scores that are not adjusted for SES using a beneficiary-level logistic regression model with contract fixed effects and beneficiary-level indicators of LIS/DE and disability status, similar to the approach currently used to adjust CAHPS patient experience measures. However, unlike CAHPS case-mix adjustment, the only adjusters are LIS/DE and disability status. Adjusted measure scores are then converted to measure stars using the 2023 rating year measure cutoffs and used to calculate Adjusted Overall and Summary Star Ratings. Unadjusted Overall and Summary Star Ratings are also determined for each contract.

The 2023 measures used in the 2024 CAI adjustment calculations are:

- Breast Cancer Screening (Part C)
- Colorectal Cancer Screening (Part C)
- Annual Flu Vaccine (Part C)
- Monitoring Physical Activity (Part C)
- Osteoporosis Management in Women who had a Fracture (Part C)
- Diabetes Care – Eye Exam (Part C)
- Diabetes Care – Blood Sugar Controlled (Part C)
- Controlling Blood Pressure (Part C)
- Reducing the Risk of Falling (Part C)
- Improving Bladder Control (Part C)
- Medication Reconciliation Post-Discharge (Part C)
- Statin Therapy for Patients with Cardiovascular Disease (Part C)
- Medication Adherence for Diabetes Medication (Part D)
- Medication Adherence for Hypertension (RAS antagonists) (Part D)
- Medication Adherence for Cholesterol (Statins) (Part D)
- MTM Program Completion Rate for CMR (Part D)
- Statin Use in Patients with Diabetes (SUPD) (Part D)

To determine the value of the CAI, contracts are first divided into an initial set of categories based on the combination of a contract's LIS/DE and disability percentages. For the adjustment for the overall and summary ratings for MA-Only and MA-PD contracts, the initial groups are formed by the ten groups of LIS/DE and quintiles of disability, thus resulting in 50 initial categories. For PDPs, the initial groups are formed using quintiles for both LIS/DE and disability. The mean differences between the Adjusted Overall or Summary Star Rating and the corresponding Unadjusted Star Rating for contracts in each initial category are determined and examined. The initial categories are collapsed to form final adjustment groups. The CAI values are the mean differences between the Adjusted Overall or Summary Star Rating and the corresponding Unadjusted Star Rating for contracts within each final adjustment group. Separate CAI values are computed for the overall and summary

ratings, and the rating-specific CAI value is the same for all contracts that fall within the same final adjustment category.

The categorization of contracts into final adjustment categories for the CAI relies on both the use of a contract's percentages of LIS/DE and disabled beneficiaries. Categories were chosen to enforce monotonicity and to yield a minimum number of 30 contracts per each final MA adjustment category and 5 contracts per each final PDP adjustment category. Puerto Rico has a unique health care market with a large percentage of low-income individuals in both Medicare and Medicaid and a complex legal history that affects the health care system in many ways. Puerto Rican beneficiaries are not eligible for LIS. Since the percentage of LIS/DE is a critical element in the categorization of contracts to identify the contract's CAI, an additional adjustment is done for contracts that solely serve the population of beneficiaries in Puerto Rico to address the lack of LIS. The additional analysis for the adjustment results in a modified percentage of LIS/DE beneficiaries that is subsequently used to categorize the contract in its final adjustment category for the CAI. Details regarding the methodology for the Puerto Rico model are provided in Attachment O.

Tables 10 and 11 provide the range of the percentages that correspond to the LIS/DE initial groups and disability quintiles for the determination of the CAI values for the Overall Rating. For example, if a contract's percentage of LIS/DE beneficiaries is 13.60%, the contract's LIS/DE initial group would be L4. The upper limit for each initial category is only included for the highest categories (L10 and D5), and the upper limit is equal to 100% for both of these categories.

Table 10: Categorization of Contract's Members into LIS/DE Initial Groups for the Overall Rating

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 6.301653
2	6.301653 to less than 8.983864
3	8.983864 to less than 12.272291
4	12.272291 to less than 17.623062
5	17.623062 to less than 23.811644
6	23.811644 to less than 32.478787
7	32.478787 to less than 48.171334
8	48.171334 to less than 76.744186
9	76.744186 to less than 100.000000
10	100.000000

Table 11: Categorization of Contract's Members into Disability Quintiles for the Overall Rating

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 15.246926
2	15.246926 to less than 22.226124
3	22.226124 to less than 29.541446
4	29.541446 to less than 43.095797
5	43.095797 to 100.000000

Table 12 provides the description of each of the final adjustment categories and the associated value of the CAI per category for the overall rating.

Table 12: Final Adjustment Categories and CAI Values for the Overall Rating

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1 - L3	D1	-0.024917
2	L4-L10 L1-L10 L1-L4	D1 D2 D3	-0.001531
3	L5-L6 L1-L6	D3 D4-D5	0.016703
4	L7-L9 L7-L8 L7	D3 D4 D5	0.036199
5	L8	D5	0.067616
6	L10 L9-L10 L9	D3 D4 D5	0.087672
7	L10	D5	0.133273

Tables 13 and 14 provide the range of the percentages that correspond to the LIS/DE initial groups and disability quintiles for the initial categories for the determination of the CAI values for the Part C summary.

Table 13: Categorization of Contract's Members into LIS/DE Initial Groups for the Part C Summary

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 5.758017
2	5.758017 to less than 8.524590
3	8.524590 to less than 11.765670
4	11.765670 to less than 17.215998
5	17.215998 to less than 23.365002
6	23.365002 to less than 31.600120
7	31.600120 to less than 46.717818
8	46.717818 to less than 74.752781
9	74.752781 to less than 100.000000
10	100.000000

Table 14: Categorization of Contract's Members into Disability Quintiles for the Part C Summary

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 14.974530
2	14.974530 to less than 21.948529
3	21.948529 to less than 29.414572
4	29.414572 to less than 42.395693
5	42.395693 to 100.000000

Table 15 provides the description of each of the final adjustment categories for the Part C summary and the associated value of the CAI for each final adjustment category.

Table 15: Final Adjustment Categories and CAI Values for the Part C Summary

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1-L7 L1-L6 L1-L5 L1-L4	D1 D2 D3 D4	-0.003487
2	L8-L10 L7-L10 L6-L7 L5-L6 L1-L5	D1 D2 D3 D4 D5	0.006987
3	L8-L10 L7-L8 L6-L7	D3 D4 D5	0.022797
4	L8	D5	0.044588
5	L9-L10	D4-D5	0.066880

Tables 16 and 17 provide the range of the percentages that correspond to the LIS/DE initial groups and the disability quintiles for the initial categories for the determination of the CAI values for the Part D summary rating for MA-PDs.

Table 16: Categorization of Contract's Members into LIS/DE Initial Groups for the MA-PD Part D Summary

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 6.507512
2	6.507512 to less than 9.702347
3	9.702347 to less than 13.812027
4	13.812027 to less than 19.485294
5	19.485294 to less than 26.769231
6	26.769231 to less than 38.003026
7	38.003026 to less than 58.059701
8	58.059701 to less than 93.000000
9	93.000000 to less than 100.000000
10	100.000000

Table 17: Categorization of Contract's Members into Disability Quintiles for the MA-PD Part D Summary

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 15.588308
2	15.588308 to less than 23.253251
3	23.253251 to less than 32.385819
4	32.385819 to less than 46.047270
5	46.047270 to 100.000000

Table 18 provides the description of each of the final adjustment categories for the MA-PD Part D summary and the associated values of the CAI for each final adjustment category.

Table 18: Final Adjustment Categories and CAI Values for the MA-PD Part D Summary

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1-L3	D1	-0.035219
2	L4-L8 L1-L7	D1 D2	-0.018599
3	L1-L6 L1-L5	D3 D4-D5	0.009901
4	L9 L8-L9 L7-L8 L6-L7 L6	D1 D2 D3 D4 D5	0.034454
5	L8 L7-L8	D4 D5	0.079744
6	L10 L9	D1-D4 D3-D5	0.110538
7	L10	D5	0.124667

Tables 19 and 20 provide the range of the percentages that correspond to the LIS/DE and disability quintiles for the initial categories for the determination of the CAI values for the PDP Part D summary. Quintiles are used for both dimensions due to the limited number of PDPs as compared to MA-PD contracts.

Table 19: Categorization of Contract's Members into Quintiles of LIS/DE for the PDP Part D Summary

LIS/DE Quintile	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 1.243781
2	1.243781 to less than 2.398356
3	2.398356 to less than 4.421104
4	4.421104 to less than 10.174281
5	10.174281 to 100.000000

Table 20: Categorization of Contract's Members into Quintiles of Disability for the PDP Part D Summary

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 6.154784
2	6.154784 to less than 8.398344
3	8.398344 to less than 11.264808
4	11.264808 to less than 15.616311
5	15.616311 to 100.000000

Table 21 provides the description of each of the final adjustment categories for the PDP Part D summary and the associated value of the CAI per final adjustment category. Note that the CAI values for the PDP Part D summary are different from the CAI values for the MA-PD Part D summary. There are five final adjustment categories for the PDP Part D summary.

Table 21: Final Adjustment Categories and CAI Values for the PDP Part D Summary

Final Adjustment Category	LIS/DE Quintile	Disability Quintile	CAI Value
1	L1	D1	-0.317950
2	L2 L1-L2	D1 D2	-0.172794
3	L3-L5 L1-L3 L1	D1-D2 D3 D4	-0.139296
4	L4-L5 L2-L5 L1-L4	D3 D4 D5	-0.067530
5	L5	D5	0.043919

Calculation Precision

CMS and its contractors have always used software called SAS (an integrated system of software products provided by SAS Institute Inc.) to perform the calculations used in producing the Star Ratings. For all measures, except the improvement measures, the precision used in scoring the measure is indicated next to the label "Data Display" within the detailed description of each measure. The improvement measures are discussed below. The domain ratings are the unweighted average of the star measures and are rounded to the nearest integer.
The improvement measures, summary, and overall ratings are calculated with at least six digits of precision after the decimal whenever the data allow it. The HEDIS measure scores have two digits of precision after the decimal. All other measures have at least six digits of precision when used in the improvement calculation.

Contracts may request a contract-specific calculation spreadsheet which emulates the actual SAS calculations from the Star Ratings mailbox during the second plan preview.

It is not possible to replicate CMS's calculations exactly due to factors including, but not limited to: using published measure data from sources other than CMS's Star Rating program which use different rounding rules, and exclusion of some contracts' ratings from publicly-posted data (e.g., terminated contracts).

Rounding Rules for Measure Scores

Measure scores are rounded to the precision indicated next to the label "Data Display" within the detailed description of each measure. Measure scores are rounded using traditional rounding rules. These are standard "round to nearest" rules prior to cut point analysis. To obtain a value with the specified level of precision, the single digit following the level of precision will be rounded. If the digit to be rounded is 0, 1, 2, 3 or 4, the value is rounded down, with no adjustment to the preceding digit. If the digit to be rounded is 5, 6, 7, 8 or 9, the value is rounded up, and a value of one is added to the preceding digit. After rounding, all digits after the specified level of precision are removed. If rounding to a whole number, the digit to be rounded is in the first decimal place. If the digit in the first decimal place is below 5, then after rounding the whole number remains unchanged and fractional parts of the number are deleted. If the digit in the first decimal place is 5 or greater, then the whole number is rounded up by adding a value of 1 and fractional parts of the number are deleted. For example, a measure listed with a Data Display of "Percentage with no decimal point" that has a value of 83.499999 rounds down to 83, while a value of 83.500000 rounds up to 84.

Rounding Rules for Summary and Overall Ratings

The results of the summary and overall calculations are rounded to the nearest half star (i.e., 0.5, 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, 5.0). Table 22 summarizes the rounding rules for converting the Part C and D summary and overall ratings into the publicly reported Star Ratings.

Table 22: Rounding Rules for Summary and Overall Ratings

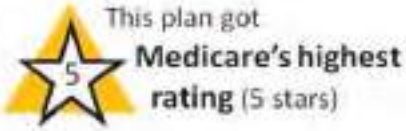
Raw Summary / Overall Score	Final Summary / Overall Rating
0.000000 to less than 0.250000	0
0.250000 to less than 0.750000	0.5
0.750000 to less than 1.250000	1.0
1.250000 to less than 1.750000	1.5
1.750000 to less than2.250000	2.0
2.250000 to less than2.750000	2.5
2.750000 to less than3.250000	3.0
3.250000 to less than 3.750000	3.5
3.750000 to less than 4.250000	4.0
4.250000 to less than 4.750000	4.5
4.750000 to 5.000000	5.0

For example, a summary or overall rating of 3.749999 rounds down to a rating of 3.5, and a rating of 3.750000 rounds up to rating of 4. That is, a score would need to be at least halfway between 3.5 and 4 (having a minimum value of 3.750000) in order to obtain the higher rating of 4.

Methodology for Calculating the High Performing Icon

A contract may receive a high performing icon as a result of its performance on the Parts C and/or D measures. The high performing icon is assigned to an MA-Only contract for achieving a 5-star Part C summary rating, a PDP contract for a 5-star Part D summary rating, and an MA-PD contract for a 5-star overall rating. Figure 3 shows the high performing icon used in the MPF:

Figure 3: The High Performing Icon



Methodology for Calculating the Low Performing Icon

A contract can receive a low performing icon as a result of its performance on the Part C and/or Part D summary ratings. The low performing icon is calculated by evaluating the Part C and Part D summary ratings for the current year and the past two years (i.e., the 2022, 2023, and 2024 Star Ratings). If the contract had any combination of Part C and/or Part D summary ratings of 2.5 or lower in all three years of data, it is marked with a low performing icon (LPI). A contract must have a rating in either Part C and/or Part D for all three years to be considered for this icon.

Figure 4 shows the low performing contract icon used in the MPF:

Figure 4: The Low Performing Icon

Table 23 shows example contracts which would receive an LPI.

Table 23: Example LPI Contracts

Contract/Rating	Rated As	2022 C	2023 C	2024 C	2022 D	2023 D	2024 D	LPI Awarded	LPI Reason
HAAAA	MA-PD	2	2.5	2.5	3	3	3	Yes	Part C
HBBBB	MA-PD	3	3	3	2.5	2	2.5	Yes	Part D
HCCCC	MA-PD	2.5	3	3	3	2.5	2.5	Yes	Part C or D
HDDDD	MA-PD	3	2.5	3	2.5	3	2.5	Yes	Part C or D
HEEEE	MA-PD	2.5	2	2.5	2	2.5	2.5	Yes	Part C and D
HFFFF	MA-Only	2.5	2	2.5	-	-	-	Yes	Part C
SAAAA	PDP	-	-	-	2.5	2.5	2	Yes	Part D

Mergers, Novations, and Consolidations

This section covers how the Star Ratings are affected by mergers, novation and consolidations. To ensure a common understanding, we begin by defining each of the terms.

- Merger: when two (or more) companies join together to become a single business. Each of these separate businesses had one or more contracts with CMS for offering health and/or drug services to Medicare beneficiaries. After the merger, all of those individual contracts with CMS are still intact, only the ownership changes in each of the contracts to the name of the new single business. Mergers can occur at any time during a contract year.
- Novation: when one company acquires another company. Each of these separate businesses had one or more contracts with CMS for offering health and/or drug services to beneficiaries. After the novation, all of those individual contracts with CMS are still intact. The owner's names of the contracts acquired are changed to the new owner's name. Novations can occur at any time during the contract year.
- Consolidation: when an organization/sponsor that has at least two contracts with CMS for offering health and/or drug services to beneficiaries combines multiple contracts into a single contract with CMS. Consolidations occur

only at the change of the contract year. The one or more contracts that will no longer exist at contract year's end are known as the consumed contracts. The contract that will still exist is known as the surviving contract and all of the beneficiaries still enrolled in the consumed contract(s) are moved to the surviving contract.

Mergers and novations do not change the ratings earned by an individual contract in any way.

For a merger or novation, the only change is the company listed as owning the contract; there is no change in contract structure, so the Star Ratings earned by the contract remains with them until the next rating cycle. This includes any High Performing or Low Performing icons earned by any of the contracts.

Consolidations become effective the first day of the calendar year. The Star Ratings are released the previous October, so they are available when open enrollment begins. In the first year following a consolidation, the measure values used in calculating the Star Ratings of the surviving contract will be based on the enrollment-weighted mean of all contracts in the consolidation (see Attachment B). The surviving contract's ratings are posted publicly, used in determining QBP ratings, and included in the Past Performance Analysis.

Reliability Requirement for Low-enrollment Contracts

HEDIS measures for contracts whose enrollment as of July 2022 was at least 500 but less than 1,000 will be included in the Star Ratings in 2024 when the contract-specific measure score reliability is equal to or greater than 0.7. The reliability calculations are implemented using SAS PROC MIXED as documented on pages 31-32 of the report "The Reliability of Provider Profiling – A Tutorial," available at https://www.rand.org/pubs/technical_reports/TR653.html.

The within-contract variance for the Transitions of Care composite measure utilizes a different formula than other HEDIS pass/fail measures because it is an average of four component measures. First, the binomial variances and standard deviations (i.e., the square root of a variance term), as discussed in the report "The Reliability of Provider Profiling – A Tutorial", are calculated for each of the four component measures. Next, pairwise correlations are computed among the four component measures. Pairwise covariance terms among the four component measures are calculated by multiplying the respective pairwise correlation and two items' standard deviations together. The final within-contract variance for the Transitions of Care composite measure is computed by summing the four variance terms and each pairwise covariance term multiplied by 2.0.

Special Needs Plan (SNP) Data

A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limits enrollment to special needs individuals. There are three major types of SNPs: 1) Chronic Condition SNP (C-SNP), 2) Dual Eligible SNP (D-SNP), and 3) Institutional SNP (I-SNP). Further details on SNP plans can be found in the glossary, Attachment R.

CMS has included three SNP-specific measures in the 2024 Star Ratings. The Part C 'Special Needs Plan Care Management' measure is based on data reported by contracts through the Medicare Part C Reporting Requirements. The two Part C 'Care for Older Adults' measures are based on HEDIS data. The data for all of these measures are reported at the plan benefit package (PBP) level, while the Star Ratings are reported at the contract level.

The methodology used to combine the PBP data to the contract level is different between the two data sources. The Part C Reporting Requirements data are summed into a contract-level rate after excluding PBPs that do not map to any PBP offered by the contract in the calendar year for which the Reporting Requirements data underwent data validation. The HEDIS data are summed into a contract-level rate as long as the contract will be offering a SNP PBP in the Star Ratings year.

The two methodologies used to combine the PBP data within a contract for these measures are described further in Attachment E.

Star Ratings and Marketing

Plan sponsors must ensure the Star Ratings document and all marketing of Star Ratings information is compliant with CMS's Medicare Marketing Guidelines. Failure to follow CMS' guidance may result in compliance action against the contract. The Medicare Marketing Guidelines were issued as Chapters 2 and 3 of the Prescription Drug Benefit Manual and the Medicare Managed Care Manual, respectively. Please direct questions about marketing Star Ratings information to your Account Manager.

Contact Information

The contact below can assist you with various aspects of the Star Ratings.

- Part C & D Star Ratings: PartCandDStarRatings@cms.hhs.gov

If you have questions or require information about the specific subject areas associated with the Star Ratings please write to those contacts directly and cc the Part C & D Star Ratings mailbox.

- CAHPS (MA & Part D): MP-CAHPS@cms.hhs.gov
- Call Center Monitoring: CallCenterMonitoring@cms.hhs.gov
- Compliance Activity Module issues (Part C): PartCCompliance@cms.hhs.gov
- Compliance Activity Module issues (Part D): PartD_Monitoring@cms.hhs.gov
- Demonstration (Medicare-Medicaid Plan) Ratings: mmcocapsmodel@cms.hhs.gov
- Disenrollment Reasons Survey: DisenrollSurvey@cms.hhs.gov
- HEDIS: HEDISquestions@cms.hhs.gov
- HOS: HOS@cms.hhs.gov
- HPMS Access issues: CMSHPMS_Access@cms.hhs.gov
- HPMS Help Desk (all other HPMS issues): HPMS@cms.hhs.gov
- Marketing: marketing@cms.hhs.gov
- Part C Compliance Activity issues: PartCCompliance@cms.hhs.gov
- Part D Compliance Activity issues: PartD_Monitoring@cms.hhs.gov
- Plan Reporting (Part C): Partcplanreporting@cms.hhs.gov
- Plan Reporting (Part D): Partd-planreporting@cms.hhs.gov
- Plan Reporting Data Validation (Part C & D): PartCandD_Data_Validation@cms.hhs.gov
- QBP Ratings and Appeals questions: QBPAppeals@cms.hhs.gov
- QBP Payment or Risk Analysis questions: riskadjustment@cms.hhs.gov

Framework and Definitions for the Domain and Measure Details Section

This page contains the formatting framework and definition of each sub-section that is used to describe the domain and measure details on the following pages.

Domain: The name of the domain to which the measures following this heading belong

Measure: The measure ID and common name of the ratings measure

Title	Description
Label for Stars:	The label that appears with the stars for this measure on Medicare.gov.
Label for Data:	The label that appears with the numeric data for this measure on HPMS and CMS.gov.
Description:	The English language description shown for the measure on Medicare.gov. The text in this sub-section has been prepared to aid beneficiaries' understanding of the nature and the purpose of the measure. We strongly encourage any public-facing explanation of the measure to use this description.
HEDIS Label:	Optional – contains the full NCQA HEDIS measure name.
Measure Reference:	Optional – this sub-section contains the location of the detailed measure specification in the NCQA documentation for all HEDIS and HEDIS-HOS measures.
Metric:	Defines how the measure is calculated.
Primary Data Source:	The primary source of the data used in the measure.
Data Source Description:	Optional – contains information about additional data sources needed for calculating the measure.
Data Source Category:	The category of this data source.
Exclusions:	Optional – lists any exclusions applied to the data used for the measure.
General Notes:	Optional – contains additional information about the measure and the data used.
Data Time Frame:	The time frame of data used from the data source. In some HEDIS measures this date range may appear to conflict with the specific data time frame defined in the NCQA Technical Specifications. In those cases, the data used by CMS are unchanged from what was submitted to NCQA. CMS uses the data time frame of the overall HEDIS submission which is the HEDIS measurement year.
General Trend:	Indicates whether high values are better or low values are better for the measure.
Statistical Method:	The methodology used for assigning stars in this measure; see the section entitled "Methodology for Assigning Part C and Part D Measure Star Ratings" for an explanation of each of the possible entries in this sub-section.
Improvement Measure:	Indicates whether this measure is included in the improvement measure.
CAI Usage:	Indicates if the measure is used in the Categorical Adjustment Index calculation.
Case-Mix Adjusted:	Indicates if the data are case mix adjusted prior to being used for the Star Ratings.
Weighting Category:	The weighting category of this measure.

Title	Description
Weighting Value:	The numeric weight for this measure in the summary and overall rating calculations.
Meaningful Measure Area:	Contains the area where this measure fits into the Meaningful Measure Framework.
CMIT #:	The CMS Measure Inventory Tool (CMIT) is the repository of record for information about the measures which CMS uses to promote healthcare quality and quality improvement.
Data Display:	The format used to the display the numeric data on Medicare.gov
Reporting Requirements:	Table indicating which organization types are required to report the measure. "Yes" for organizations required to report; "No" for organizations not required to report.
Cut Points:	Table containing the cut points used in the measure. For non-CAHPS measures, excluding new measures or measures with substantive specification changes for the first three years, the cut points are after the application of Tukey outlier deletion, mean resampling, and guardrails. The Health Plan Quality Improvement and Drug Plan Quality Improvement measure cut points are after the application of Tukey outlier deletion and mean resampling. For CAHPS measures, the table contains the base group cut points which are used prior to the final star assignment rules being applied.

Part C Domain and Measure Details

See Attachment C for the national averages of individual Part C measures.

Domain: 1 - Staying Healthy: Screenings, Tests and Vaccines

Measure: C01 - Breast Cancer Screening

Title	Description
Label for Stars:	Breast Cancer Screening
Label for Data:	Breast Cancer Screening
Description:	Percent of female plan members aged 52-74 who had a mammogram during the past two years.
HEDIS Label:	Breast Cancer Screening (BCS)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 95
Metric:	The percentage of women MA enrollees 50 to 74 years of age (denominator) as of December 31 of the measurement year who had a mammogram to screen for breast cancer in the past two years(numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans

Exclusions:

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria:
  - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits.
  - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
  - A dispensed dementia medication (Dementia Medications List).
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set)

Title	Description
	during the measurement year (optional) Bilateral mastectomy any time during the member's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy: • Bilateral mastectomy (Bilateral Mastectomy Value Set). • Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set). • Two unilateral mastectomies (Unilateral Mastectomy Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1 of the measurement year, the service date for the second unilateral mastectomy must be on or after February 15. • Both of the following (on the same or a different date of service): – Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Right Modifier Value Set) (same date of service). – Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) (same date of service). • Absence of the left breast (Absence of Left Breast Value Set) and absence of the right breast (Absence of Right Breast Value Set) on the same or different date of service. • History of bilateral mastectomy (History of Bilateral Mastectomy Value Set). • Left unilateral mastectomy (Unilateral Mastectomy Left Value Set) and right unilateral mastectomy (Unilateral Mastectomy Right Value Set) on the same or different date of service.
	Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1

Title	Description
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00093-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 52%	52% to less than 63%	63% to less than 71%	71% to less than 79%	greater than or equal to 79%

Measure: C02 - Colorectal Cancer Screening

Title	Description
Label for Stars:	Colorectal Cancer Screening
Label for Data:	Colorectal Cancer Screening
Description:	Percent of plan members aged 50-75 who had appropriate screening for colon cancer.
HEDIS Label:	Colorectal Cancer Screening (COL)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 105
Metric:	The percentage of MA enrollees aged 50 to 75 (denominator) as of December 31 of the measurement year who had appropriate screenings for colorectal cancer (numerator).
Primary Data Source:	HEDIS Patient-level Data
Data Source Category:	Health and Drug Plans

Exclusions:

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year (optional) Refer to Administrative Specification for

Title	Description
	exclusion criteria. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year.
	Contracts whose enrollment was at least 500 but less than 1,000 as of the enrollment report and having measure score reliability less than 0.7 are excluded.
	Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00139-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 50%	50% to less than 61%	61% to less than 71%	71% to less than 80%	greater than or equal to 80%

Measure: C03 - Annual Flu Vaccine

Title	Description
Label for Stars:	Yearly Flu Vaccine
Label for Data:	Yearly Flu Vaccine

Title	Description

Description: Percent of plan members who got a vaccine (flu shot).

Metric: The percentage of sampled Medicare enrollees (denominator) who received an influenza vaccination (numerator).

Primary Data Source: CAHPS

Data Source Description: CAHPS Survey Question (question number varies depending on survey type):

- Have you had a flu shot since July 1, 2022?

Data Source Category: Survey of Enrollees

General Notes: This measure is not case-mix adjusted.

CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2023 – 06/2023

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Wellness and Prevention

CMIT #: 00259-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 63%	63% to less than 67%	67% to less than 74%	74% to less than 78%	greater than or equal to78%

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C04 - Monitoring Physical Activity

Title	Description
Label for Stars:	Monitoring Physical Activity
Label for Data:	Monitoring Physical Activity
Description:	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase, or maintain their physical activity during the year.
HEDIS Label:	Physical Activity in Older Adults (PAO)
Measure Reference:	NCQA HEDIS Measurement Year 2021 Specifications for the Medicare Health Outcomes Survey Volume 6, page 37
Metric:	The percentage of sampled Medicare members 65 years of age or older who had a doctor's visit in the past 12 months (denominator) and who received advice to start, increase or maintain their level exercise or physical activity (numerator).
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 23 Follow-up Data collection (2022) and Cohort 25 Baseline data collection (2022). HOS Survey Question 42: In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise. HOS Survey Question 43: In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.
Data Source Category:	Survey of Enrollees
Exclusions:	Members who responded "I had no visits in the past 12 months" to Question 42 are excluded from results calculations for Question 43. Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded.
Data Time Frame:	07/19/2022 – 11/01/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included

Title	Description

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2021 disasters.

Meaningful Measure Area: Wellness and Prevention

CMIT #: 00540-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 42%	42% to less than 48%	48% to less than 53%	53% to less than 58%	greater than or equal to 58%

Domain: 2 - Managing Chronic (Long Term) Conditions

Measure: C05 - Special Needs Plan (SNP) Care Management

Title	Description
Label for Stars:	Members Whose Plan Did an Assessment of Their Health Needs and Risks
Label for Data:	Members Whose Plan Did an Assessment of Their Health Needs and Risks
Description:	Percent of members whose plan did an assessment of their health needs and risks in the past year. The results of this review are used to help the member get the care they need. (Medicare does not collect this information from all plans. Medicare collects it only for Special Needs Plans. These plans are a type of Medicare Advantage plan designed for certain people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)
Metric:	This measure is defined as the percent of eligible Special Needs Plan (SNP) enrollees who received a health risk assessment (HRA) during the measurement year. The denominator for this measure is the sum of the number of new enrollees due for an Initial HRA (Element A) and the number of enrollees eligible for an annual reassessment HRA (Element B). The numerator for this measure is the sum of the number of initial HRAs performed on new enrollees (Element C) and the number of annual reassessments performed on enrollees eligible for a reassessment (Element F). The equation for calculating the SNP Care Management Assessment Rate is: [Number of initial HRAs performed on new enrollees (Element C) + Number of annual reassessments performed on enrollees eligible for a reassessment (Element F)] / [Number of new enrollees due for an Initial HRA (Element A) + Number of enrollees eligible for an annual reassessment HRA (Element B)]
Primary Data Source:	Part C Plan Reporting
Data Source Description:	Data reported by contracts to CMS per the Part C Reporting Requirements. Validation for data performed during the 2023 Data Validation cycle.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts and PBPs with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2023) are excluded and listed as "No data available." SNP Care Management Assessment Rates are not provided for contracts that did not score at least 95% on data validation for the SNP Care Management reporting section or were not compliant with data validation standards/sub-standards for any of the following SNP Care Management data elements: • Number of new enrollees due for an initial HRA (Element A) • Number of enrollees eligible for an annual reassessment HRA (Element B) • Number of initial HRAs performed on new enrollees (Element C)

Title	Description
	• Number of annual reassessments performed on enrollees eligible for reassessment (Element F) Contracts excluded from the SNP Care Management Assessment Rates due to data validation issues are shown as "CMS identified issues with this plan's data." Contracts can view their data validation results in HPMS (https://hpms.cms.gov/). To access this page, from the top menu select "Monitoring," then "Plan Reporting Data Validation." Select the appropriate contract year. Select the PRDVM Reports. Select "Score Detail Report." Select the applicable reporting section. If you cannot see the Plan Reporting Data Validation module, contact CMSHPMS_Access@cms.hhs.gov. Additionally, contracts must have 30 or more enrollees in the denominator [Number of new enrollees due for an Initial HRA (Element A) + Number of enrollees eligible for an annual HRA (Element B) ≥ 30] in order to have a calculated rate. Contracts with fewer than 30 eligible enrollees are listed as "No data available."
General Notes:	More information about the data used to calculate this measure can be found in Attachment E. The Part C reporting requirement fields listed below are not used in calculating this measure: • Data Element D Number of initial HRA refusals • Data Element E Number of initial HRAs where SNP is unable to reach new enrollees • Data Element G Number of annual reassessment refusals • Data Element H Number of annual reassessments where SNP is unable to reach enrollee
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Title	Description

Meaningful Measure Area: Chronic Conditions

CMIT #: 00685-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	No	Yes	Yes	No	No	No

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 42%	42% to less than 57%	57% to less than 74%	74% to less than 85%	greater than or equal to 85%

Measure: C06 - Care for Older Adults – Medication Review

Title	Description
Label for Stars:	Yearly Review of All Medications and Supplements Being Taken
Label for Data:	Yearly Review of All Medications and Supplements Being Taken
Description:	Percent of plan members whose doctor or clinical pharmacist reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year. (Medicare does not collect this information from all plans. Medicare collects it only for Special Needs Plans. These plans are a type of Medicare Advantage plan designed for certain people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)
HEDIS Label:	Care for Older Adults (COA) – Medication Review
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 118
Metric:	The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Medication List Value Set) (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	SNP benefit packages whose enrollment was less than 30 as of February 2022 SNP Comprehensive Report were excluded from this measure.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1

Title	Description
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00110-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	No	Yes	Yes	No	No	No

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 72%	72% to less than 84%	84% to less than 93%	93% to less than 98%	greater than or equal to 98%

Measure: C07 - Care for Older Adults – Pain Assessment

Title	Description
Label for Stars:	Yearly Pain Screening or Pain Management Plan
Label for Data:	Yearly Pain Screening or Pain Management Plan
Description:	Percent of plan members who had a pain screening at least once during the year. (Medicare does not collect this information from all plans. Medicare collects it only for Special Needs Plans. These plans are a type of Medicare Advantage plan designed for certain people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)
HEDIS Label:	Care for Older Adults (COA) – Pain Screening
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 118
Metric:	The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one pain assessment (Pain Assessment Value Set) plan during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	SNP benefit packages whose enrollment was less than 30 as of February 2022 SNP Comprehensive Report were excluded from this measure.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00111-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	No	Yes	Yes	No	No	No

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 74%	74% to less than 83%	83% to less than 91%	91% to less than 96%	greater than or equal to 96%

Measure: C08 - Osteoporosis Management in Women who had a Fracture

Title	Description
Label for Stars:	Osteoporosis Management
Label for Data:	Osteoporosis Management
Description:	Percent of female plan members who broke a bone and got screening or treatment for osteoporosis within 6 months.
HEDIS Label:	Osteoporosis Management in Women Who Had a Fracture (OMW)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 228
Metric:	The percentage of woman MA enrollees 67 - 85 who suffered a fracture (denominator) and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans

Title	Description

Exclusions:

- Members who had a BMD test (Bone Mineral Density Tests Value Set) during the 730 days (24 months) prior to the IESD.
- Members who had a claim/encounter for osteoporosis therapy (Osteoporosis Medications Value Set) during the 365 days (12 months) prior to the IESD.
- Members who received a dispensed prescription or had an active prescription to treat osteoporosis (Osteoporosis Medications List) during the 365 days (12 months) prior to the IESD.
- Members who are enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
- Members living long-term in an institution any time during the measurement year.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2022 – 12/31/2022

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00484-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars

Title	Description				
	less than 29%	29% to less than 42%	42% to less than 55%	55% to less than 71%	greater than or equal to 71%

Measure: C09 - Diabetes Care – Eye Exam

Title	Description
Label for Stars:	Eye Exam to Check for Damage from Diabetes
Label for Data:	Eye Exam to Check for Damage from Diabetes
Description:	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.
HEDIS Label:	Eye Exam for Patients with Diabetes (EED)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 203
Metric:	The percentage of diabetic MA enrollees age 18-75 with diabetes (type 1 and type 2) (denominator) who had an eye exam (retinal) performed during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with both frailty (Frailty Value Set) and advanced illness (Advanced Illness Value Set) during the measurement year. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same.

Title	Description
	If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00203-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 52%	52% to less than 65%	65% to less than 73%	73% to less than 81%	greater than or equal to 81%

Measure: C10 - Diabetes Care – Blood Sugar Controlled

Title	Description
Label for Stars:	Plan Members with Diabetes whose Blood Sugar is Under Control
Label for Data:	Plan Members with Diabetes whose Blood Sugar is Under Control

Title	Description
Description:	Percent of plan members with diabetes who had an A1c lab test during the year that showed their average blood sugar is under control.
HEDIS Label:	Hemoglobin A1c Control for Patients with Diabetes (HBD) – HbA1c poor control (>9.0%)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 184
Metric:	The percentage of diabetic MA enrollees age 18-75 (denominator) whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year (numerator). (This measure for public reporting is reverse scored so higher scores are better.) To calculate this measure, subtract the submitted rate from 100.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with both frailty (Frailty Value Set) and advanced illness (Advanced Illness Value Set) during the measurement year. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same. If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022

Title	Description
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00204-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 58%	58% to less than 72%	72% to less than 80%	80% to less than 87%	greater than or equal to 87%

Measure: C11 - Controlling Blood Pressure

Title	Description
Label for Stars:	Controlling Blood Pressure
Label for Data:	Controlling Blood Pressure
Description:	Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure.
HEDIS Label:	Controlling High Blood Pressure (CBP)
Measure Reference:	NCQA HEDIS MY 2022 Technical Specifications Volume 2, page 152
Metric:	The percentage of MA members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose BP was adequately controlled (<140/90 mm Hg) (numerator).
Primary Data Source:	HEDIS

Title	Description
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude members who meet any of the following criteria: • Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 81 years of age and older as of December 31 of the measurement year with frailty (Frailty Value Set) during the measurement year. • Members 66–80 years of age and older as of December 31 of the measurement year with frailty (Frailty Value Set) and advanced illness during the measurement year. • A dispensed dementia medication. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. (Optional) • Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis. • Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. • Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcomes Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00167-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 58%	58% to less than 68%	68% to less than 74%	74% to less than 82%	greater than or equal to 82%

Measure: C12 - Reducing the Risk of Falling

Title	Description
Label for Stars:	Reducing the Risk of Falling
Label for Data:	Reducing the Risk of Falling
Description:	Percent of plan members with a problem falling, walking, or balancing who discussed it with their doctor and received a recommendation for how to prevent falls during the year.
HEDIS Label:	Fall Risk Management (FRM)
Measure Reference:	NCQA HEDIS Measurement Year 2021 Specifications for the Medicare Health Outcomes Survey Volume 6, page 39
Metric:	The percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months (denominator) and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner (numerator).

Title	Description
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 23 Follow-up Data collection (2022) and Cohort 25 Baseline data collection (2022). HOS Survey Question 44: A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? HOS Survey Question 45: Did you fall in the past 12 months? HOS Survey Question 46: In the past 12 months have you had a problem with balance or walking? HOS Survey Question 47: Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include: • Suggest that you use a cane or walker. • Suggest that you do an exercise or physical therapy program. • Suggest a vision or hearing test.
Data Source Category:	Survey of Enrollees
Exclusions:	Members who responded "I had no visits in the past 12 months" to Question 44 or Question 47 are excluded from results calculations. Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded.
Data Time Frame:	07/19/2022 – 11/01/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Safety

Title	Description
CMIT #:	00646-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 47%	47% to less than 53%	53% to less than 60%	60% to less than 70%	greater than or equal to 70%

Measure: C13 - Improving Bladder Control

Title	Description
Label for Stars:	Improving Bladder Control
Label for Data:	Improving Bladder Control
Description:	Percent of plan members with a urine leakage problem in the past 6 months who discussed treatment options with a provider.
HEDIS Label:	Management of Urinary Incontinence in Older Adults (MUI)
Measure Reference:	NCQA HEDIS Measurement Year 2021 Specifications for the Medicare Health Outcomes Survey Volume 6, page 34
Metric:	The percentage of Medicare members 65 years of age or older who reported having any urine leakage in the past six months (denominator) and who discussed treatment options for their urinary incontinence with a provider (numerator).
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 23 Follow-up Data collection (2022) and Cohort 25 Baseline data collection (2022). HOS Survey Question 38: Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? HOS Survey Question 41: There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches? Member choices must be as follows to be included in the denominator: • Q38 = "Yes." • Q41 = "Yes" or "No." The numerator contains the number of members in the denominator who indicated they discussed treatment options for their urinary incontinence with a health care provider. Member choice must be as follows to be included in the numerator:

Title	Description

- Q41 = "Yes."

Data Source Category: Survey of Enrollees

Exclusions: Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded.

Data Time Frame: 07/19/2022 – 11/01/2022

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2021 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00378-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 38%	38% to less than 42%	42% to less than 47%	47% to less than 51%	greater than or equal to 51%

Measure: C14 - Medication Reconciliation Post-Discharge

Title	Description
Label for Stars:	The Plan Makes Sure Member Medication Records Are Up-to-Date After Hospital Discharge
Label for Data:	The Plan Makes Sure Member Medication Records Are Up-to-Date After Hospital Discharge
Description:	This shows the percent of plan members whose medication records were updated within 30 days after leaving the hospital. To update the record, a doctor or other health care professional looks at the new medications prescribed in the hospital and compares them with the other medications the patient takes. Updating medication records can help to prevent errors that can occur when medications are changed.
HEDIS Label:	Medication Reconciliation Post-Discharge (MRP)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 330
Metric:	The percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Seamless Care Coordination

Title	Description
CMIT #:	00441-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 38%	38% to less than 52%	52% to less than 68%	68% to less than 82%	greater than or equal to 82%

Measure: C15 - Plan All-Cause Readmissions

Title	Description
Label for Stars:	Readmission to a Hospital within 30 Days of Being Discharged (more stars are better because it means fewer members are being readmitted)
Label for Data:	Readmission to a Hospital within 30 Days of Being Discharged (lower percentages are better because it means fewer members are being readmitted)
Description:	Percent of plan members aged 18 and older discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason. (Patients may have been readmitted back to the same hospital or to a different one. Rates of readmission take into account how sick patients were when they went into the hospital the first time. This "risk-adjustment" helps make the comparisons between plans fair and meaningful.)
HEDIS Label:	Plan All-Cause Readmissions (PCR)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 498
Metric:	The percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for members 18 years of age and older using the following formula to control for differences in the case mix of patients across different contracts. For contract A, their case-mix adjusted readmission rate relative to the national average is the observed readmission rate for contract A divided by the expected readmission rate for contract A. This ratio is then multiplied by the national average observed rate. See Attachment F: Calculating MeasureC15: Plan All-Cause Readmissions (18+) for the complete formula, example calculation and National Average Observation value used to complete this measure.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude hospital stays for the following reasons: • The member died during the stay. • Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.

Title	Description
	• A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2021 enrollment report are excluded from this measure. As listed in the HEDIS Technical Specifications. CMS has excluded contracts whose denominator was less than 150.

Data Time Frame: 01/01/2022 – 12/31/2022

General Trend: Lower is better

Statistical Method: Clustering

Improvement Measure: Not Included

CAI Usage: Included

Case-Mix Adjusted: Yes

Weighting Category: Outcome Measure

Weighting Value: 1

Major Disaster: New Measure Hold Harmless Provision.

Meaningful Measure Area: Admissions and Readmissions to Hospitals

CMIT #: 00561-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
greater than 13%	greater than 11% to less than or equal to 13%	greater than 10% to less than or equal to 11%	greater than 8% to less than or equal to 10%	less than or equal to 8%

Measure: C16 - Statin Therapy for Patients with Cardiovascular Disease

Title	Description
Label for Stars:	The Plan Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol
Label for Data:	The Plan Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol
Description:	This rating is based on the percent of plan members with heart disease who get the right type of cholesterol-lowering drugs. Health plans can help make sure their members are prescribed medications that are more effective for them.
HEDIS Label:	Statin Therapy for Patients with Cardiovascular Disease (SPC)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 168
Metric:	The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) (denominator) and were dispensed at least one high or moderate-intensity statin medication during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude members who meet any of the following criteria: • Pregnancy (Pregnancy Value Set) during the measurement year or year prior to the measurement year. • In vitro fertilization (IVF Value Set) in the measurement year or year prior to the measurement year. • Dispensed at least one prescription for clomiphene (Table SPC-A) during the measurement year or the year prior to the measurement year. • ESRD (ESRD Value Set) during the measurement year or the year prior to the measurement year. • Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. • Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year with frailty (Frailty Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria:

Title	Description

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
- A dispensed dementia medication (Dementia Medications List).

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2022 – 12/31/2022

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00700-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 79%	79% to less than 84%	84% to less than 86%	86% to less than 90%	greater than or equal to 90%

Measure: C17 - Transitions of Care

Title	Description
Label for Stars:	After hospital stay, members receive information and care they need
Label for Data:	After hospital stay, members receive information and care they need
Description:	This rating is based on the percent of plan members who got follow-up care after a hospital stay. Follow-up care includes: getting information about their health problem and what to do next, having a visit or call with a doctor, and having a doctor or pharmacist make sure the plan member's medication records are up to date.
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 330
Metric:	The average of the rates for Transitions of Care - Medication Reconciliation Post-Discharge, Transitions of Care - Notification of Inpatient Admission, Transitions of Care - Patient Engagement After Inpatient Discharge, and Transitions of Care - Receipt of Discharge Information.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Members that do not have continuous enrollment from the date of discharge through 30 days after discharge (31 total days) are excluded. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	New Measure Hold Harmless Provision.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00729-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 40%	40% to less than 52%	52% to less than 64%	64% to less than 78%	greater than or equal to 78%

Measure: C18 - Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Title	Description
Label for Stars:	Members with 2 or more chronic conditions receive follow-up care within 7 days after an emergency department visit
Label for Data:	Members with 2 or more chronic conditions receive follow-up care within 7 days after an emergency department visit
Description:	This rating is based on the percent of plan members with 2 or more chronic conditions who got follow-up care within 7 days after they had an emergency department (ED) visit. Depending on the person's needs this might be a visit with a health care provider, an appointment with a case manager, or a home visit.
HEDIS Label:	Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 340
Metric:	The percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.
Primary Data Source:	HEDIS

Title	Description
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. These events are excluded from the measure because admission to an acute or nonacute setting may prevent an outpatient follow-up visit from taking place Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	New Measure Hold Harmless Provision.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00263-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 44%	44% to less than 53%	53% to less than 60%	60% to less than 68%	greater than or equal to 68%

Domain: 3 - Member Experience with Health Plan

Measure: C19 - Getting Needed Care

Title	Description
Label for Stars:	Ease of Getting Needed Care and Seeing Specialists
Label for Data:	Ease of Getting Needed Care and Seeing Specialists (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get needed care, including care from specialists.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for a member to get needed care and see specialists. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? • In the last 6 months, how often was it easy to get the care, tests or treatment you needed?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Title	Description
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00293-02-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 76	76 to less than 78	78 to less than 81	81 to less than 83	greater than or equal to 83

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C20 - Getting Appointments and Care Quickly

Title	Description
Label for Stars:	Getting Appointments & Care Quickly
Label for Data:	Getting Appointments & Care Quickly (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how quickly members get appointments and care.
Metric:	This case-mix adjusted composite measure is used to assess how quickly the member was able to get appointments and care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? • In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
General Trend:	Higher is better

Title	Description
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00292-01-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 74	74 to less than 76	76 to less than 78	78 to less than 80	greater than or equal to 80

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C21 - Customer Service

Title	Description
Label for Stars:	Health Plan Provides Information or Help When Members Need It
Label for Data:	Health Plan Provides Information or Help When Members Need It (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for the member to get information and help when needed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS

Data Source Description:

- CAHPS Survey Questions (question numbers vary depending on survey type):

Title	Description
	• In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms from your health plan easy to fill out?

Data Source Category: Survey of Enrollees

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2023 – 06/2023

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 4

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00181-01-C-PARTC

Data Display: Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 88	88 to less than 89	89 to less than 90	90 to less than 92	greater than or equal to 92

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C22 - Rating of Health Care Quality

Title	Description
Label for Stars:	Members' Rating of Health Care Quality
Label for Data:	Members' Rating of Health Care Quality (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned from members who rated the quality of the health care they received.
Metric:	This case-mix adjusted measure is used to assess members' view of the quality of care received from the health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00642-01-C-PARTC
Data Display:	Numeric with no decimal place

Title	Description

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 84	84 to less than 85	85 to less than 87	87 to less than 88	greater than or equal to 88

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C23 - Rating of Health Plan

Title	Description
Label for Stars:	Members' Rating of Health Plan
Label for Data:	Members' Rating of Health Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned from members who rated the health plan.
Metric:	This case-mix adjusted measure is used to assess members' overall view of their health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure

Title	Description

Weighting Value: 4

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Person-Centered Care

CMIT #: 00643-02-C-PARTC

Data Display: Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 84	84 to less than 85	85 to less than 88	88 to less than 89	greater than or equal to 89

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C24 - Care Coordination

Title	Description

Label for Stars: Coordination of Members' Health Care Services

Label for Data: Coordination of Members' Health Care Services (on a scale from 0 to 100)

Description: Percent of the best possible score the plan earned on how well the plan coordinates members' care. (This includes whether doctors had the records and information they needed about members' care and how quickly members got their test results.)

Metric: This case-mix adjusted composite measure is used to assess Care Coordination. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale of 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Primary Data Source: CAHPS

Data Source Description: CAHPS Survey Questions (question numbers vary depending on survey type):

- In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?

Title	Description
	• In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

Data Source Category: Survey of Enrollees

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2023 – 06/2023

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 4

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Seamless Care Coordination

CMIT #: 00106-02-C-PARTC

Data Display: Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 83	83 to less than 84	84 to less than 86	86 to less than 87	greater than or equal to 87

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Domain: 4 - Member Complaints and Changes in the Health Plan's Performance

Measure: C25 - Complaints about the Health Plan

Title	Description
Label for Stars:	Complaints about the Health Plan (more stars are better because it means fewer complaints)
Label for Data:	Complaints about the Health Plan (lower numbers are better because it means fewer complaints)
Description:	Rate of complaints filed with Medicare about the health plan.
Metric:	Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the Complaints Tracking Module (CTM)) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period). Number of Days in Period = 366 for leap years, 365 for all other years. • Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data. • Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract. • A contract's failure to follow CMS's CTM Standard Operating Procedures will not result in CMS's adjustment of the data used for these measures.
Primary Data Source:	Complaints Tracking Module (CTM)
Data Source Description:	Data were obtained from the CTM in the Health Plan Management System (HPMS) based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. The status of any specific complaint at the time the data are pulled stands for use in the reports. Any changes to the complaints data subsequent to the data pull cannot be excluded retroactively. CMS allows for an approximate 6-month "wash out" period to account for any adjustments per CMS's CTM Standard Operating Procedures. Therefore, all Plan Requests for 2022 complaints made by June 30, 2023 are captured. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis. Monthly enrollment files from HPMS were used to calculate the average enrollment for the contract for the measurement period.
Data Source Category:	CMS Administrative Data
Exclusions:	On May 10, 2019, CMS released an HPMS memo on the Complaints Tracking Module (CTM) Updated Standard Operating Procedures (SOP). Plans should review all complaints at intake and verify the contract assignment and issue level. The APPENDIX A - Category and Subcategory Listing in the SOP lists the subcategories that are excluded. Complaint rates are not calculated for contracts with average enrollment of less than 800 enrollees during the measurement period.
Data Time Frame:	01/01/2022 – 12/31/2022

Title	Description
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00142-02-C-PARTC
Data Display:	Numeric with 2 decimal places

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 0.75	less than 0.5 to 0.75	less than 0.32 to 0.5	less than 0.14 to 0.32	less than or equal to 0.14

Measure: C26 - Members Choosing to Leave the Plan

Title	Description
Label for Stars:	Members Choosing to Leave the Plan (more stars are better because it means fewer members choose to leave the plan)
Label for Data:	Members Choosing to Leave the Plan (lower percentages are better because that indicates fewer members choose to leave the plan)
Description:	Percent of plan members who chose to leave the plan.
Metric:	The percent of members who chose to leave the contract comes from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the contract between January 1, 2022–December 31, 2022 (numerator) divided by all members enrolled in the contract at any time during 2022 (denominator).
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)

Title	Description
Data Source Category:	CMS Administrative Data
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • Contracts with less than 1,000 enrollees • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2022 and 12/31/2022 who disenrolled from the contract with any one of the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan 13 - Disenrollment because of enrollment in another Plan 14 - Retroactive 99 - Other (not supplied by beneficiary). If all potential members in the numerator meet one or more of the exclusion criteria, the measure result will be "Not enough data available". The Disenrollment Reasons Survey (DRS) data available in the HPMS plan preview and in the CMS downloadable Master Table, are not used in the calculation of this measure. The DRS data are presented in each of the systems for information purposes only.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included

Title	Description
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00446-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 41%	less than 29% to 41%	less than 18% to 29%	less than 10% to 18%	less than or equal to 10%

Measure: C27 - Health Plan Quality Improvement

Title	Description
Label for Stars:	Improvement (if any) in the Health Plan's Performance
Label for Data:	Improvement (if any) in the Health Plan's Performance
Description:	This shows how much the health plan's performance improved or declined from one year to the next. If a plan receives **1 or 2 stars**, it means, on average, the plan's scores **declined** (got worse). If a plan receives **3 stars**, it means, on average, the plan's scores **stayed about the same**. If a plan receives **4 or 5 stars**, it means, on average, the plan's scores **improved**. Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.
Metric:	The numerator is the net improvement, which is a weighted sum of the number of significantly improved measures minus the number of significantly declined measures. The denominator is the sum of the weights associated with the measures eligible for the improvement measure (i.e., the measures that were included in the 2022 and 2023 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2022 and 2023 Star Ratings

Title	Description
Data Source Category:	Star Ratings
Exclusions:	Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.
General Notes:	Attachment H contains the formulas used to calculate the improvement measure and lists indicating which measures were used.
Data Time Frame:	Not Applicable
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Improvement Measure
Weighting Value:	5
Major Disaster:	Includes only measures which have data from both years.
Meaningful Measure Area:	Person-centered Care
CMIT #:	00300-01-C-PARTC
Data Display:	Not Applicable

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than -0.246067	-0.246067 to less than 0	0 to less than 0.173502	0.173502 to less than 0.393451	greater than or equal to 0.393451

Domain: 5 - Health Plan Customer Service

Measure: C28 - Plan Makes Timely Decisions about Appeals

Title	Description
Label for Stars:	Health Plan Makes Timely Decisions about Appeals
Label for Data:	Health Plan Makes Timely Decisions about Appeals
Description:	This rating shows how fast a plan sends information for an independent review.
Metric:	Percent of appeals timely processed by the plan (numerator) out of all the plan's appeals decided by the Independent Review Entity (IRE) (includes upheld, overturned, partially overturned appeals and dismissed because the plan agreed to cover) (denominator). This is calculated as: ([Number of Timely Appeals] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned] + [Appeals Dismissed Because Plan Agreed to Cover])) * 100
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. The timeliness is based on the actual IRE received date and is compared to the date the appeal should have been received by the IRE.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	If the denominator is ≤ 10, the result is "Not enough data available." Dismissed for reasons other than the plan agreed to cover and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers. The number of timely appeals can be calculated using this formula: [Number of Timely Appeals] = ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]) + [Appeals Dismissed Because Plan Agreed to Cover]) - [Late] Note: When reviewing IRE data from the Maximus appeals website found at http://www.medicareappeal.com/AppealSearch and in data files, appeal disposition codes have been updated from the prior codes. Below is a crosswalk of previous appeal disposition codes and current codes:

Previous Field Name	Current Field Name
Upheld	Unfavorable
Overturn	Favorable
Partially Overturn	Partially favorable

Title	Description
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Affordability and Efficiency
CMIT #:	00562-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 84%	84% to less than 88%	88% to less than 94%	94% to less than 98%	greater than or equal to 98%

Measure: C29 - Reviewing Appeals Decisions

Title	Description
Label for Stars:	Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer
Label for Data:	Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer
Description:	This rating shows how often an independent reviewer found the health plan's decision to deny coverage to be reasonable.
Metric:	Percent of appeals where a plan's decision was "upheld" by the Independent Review Entity (IRE) (numerator) out of all the plan's appeals (upheld, overturned, and partially overturned appeals only) that the IRE reviewed (denominator). This is calculated as:

Title	Description
	([Appeals Upheld] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]))* 100.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. If a Reopening occurs and is decided prior to June 30, 2023, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after June 30, 2023 are not reflected in these data the original decision result is used. The results of appeals that occur beyond Level 2 (i.e., Administrative Law Judge or Medicare Appeals Council appeals) are not included in the data.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	If the minimum number of appeals (upheld + overturned + partially overturned) is ≤ 10, the result is "Not enough data available." Dismissed and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Affordability and Efficiency
CMIT #:	00652-01-C-PARTC
Data Display:	Percentage with no decimal place

Title	Description

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 87%	87% to less than 92%	92% to less than 96%	96% to less than 100%	equal to 100%

Measure: C30 - Call Center – Foreign Language Interpreter and TTY Availability

Title	Description
Label for Stars:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Health Plan
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Health Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by people who called the health plan's prospective enrollee customer service phone line.
Metric:	The calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within eight minutes. Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within seven minutes.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, organizations that did not have a phone number accessible to survey callers, and MAOs, MA-PDs, and MMPs under sanction.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/2023 – 05/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included

Title	Description
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	4
Major Disaster:	No adjustment for 2021 or 2022 disasters.
Meaningful Measure Area:	Person-centered Care
CMIT #:	00096-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	Yes	No	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 72%	72% to less than 83%	83% to less than 92%	92% to less than 97%	greater than or equal to 97%

Part D Domain and Measure Details

See Attachment C for the national averages of individual Part D measures.

Domain: 1 - Drug Plan Customer Service

Measure: D01 - Call Center – Foreign Language Interpreter and TTY Availability

Title	Description
Label for Stars:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by people who called the drug plan's prospective enrollee customer service line.
Metric:	The calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the plan's Medicare Part D benefit within eight minutes. Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the plan's Medicare Part D benefit within seven minutes.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, organizations that did not have a phone number accessible to survey callers, and MA-PDs, PDPs, and MMPs under sanction.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/2023 – 05/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access

Title	Description

Weighting Value: 4

Major Disaster: No adjustment for 2021 or 2022 disasters.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00096-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 73%	73% to less than 86%	86% to less than 96%	96% to less than 99%	greater than or equal to 99%
PDP	less than 91%	91% to less than 97%	97% to less than 98%	98% to less than 100%	equal to 100%

Domain: 2 - Member Complaints and Changes in the Drug Plan's Performance

Measure: D02 - Complaints about the Drug Plan

Title	Description
Label for Stars:	Complaints about the Drug Plan (more stars are better because it means fewer complaints)
Label for Data:	Complaints about the Drug Plan (number of complaints for every 1,000 members). (Lower numbers are better because it means fewer complaints.)
Description:	Rate of complaints filed with Medicare about the drug plan.
Metric:	Rate of complaints about the drug plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the Complaints Tracking Module (CTM)) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period). Number of Days in Period = 366 for leap years, 365 for all other years. • Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data. • Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract. • A contract's failure to follow CMS's CTM Standard Operating Procedures will not result in CMS's adjustment of the data used for these measures.
Primary Data Source:	Complaints Tracking Module (CTM)
Data Source Description:	Data were obtained from the CTM in the Health Plan Management System (HPMS) based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. The status of any specific complaint at the time the data are pulled stands for use in the reports. Any changes to the complaints data subsequent to the data pull cannot be excluded retroactively. CMS allows for an approximate 6-month "wash out" period to account for any adjustments per CMS's CTM Standard Operating Procedures. Therefore, all Plan Requests for 2022 complaints made by June 30, 2023 are captured Complaint rates per 1,000 enrollees are adjusted to a 30-day basis. Monthly enrollment files from HPMS were used to calculate the average enrollment for the contract for the measurement period.
Data Source Category:	CMS Administrative Data
Exclusions:	On May 10, 2019, CMS released an HPMS memo on the Complaints Tracking Module (CTM) Updated Standard Operating Procedures (SOP). Plans should review all complaints at intake and verify the contract assignment and issue level. The APPENDIX A - Category and Subcategory Listing in the SOP lists the subcategories that are excluded. Complaint rates are not calculated for contracts with average enrollment of less than 800 enrollees during the measurement period.
Data Time Frame:	01/01/2022 – 12/31/2022

Title	Description
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00142-02-C-PARTD
Data Display:	Numeric with 2 decimal places

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 0.75	greater than0.5 to 0.75	greater than 0.32 to 0.5	greater than 0.14 to 0.32	less than or equal to 0.14
PDP	greater than 0.14	greater than0.09 to 0.14	greater than 0.06 to 0.09	greater than 0.02 to 0.06	less than or equal to 0.02

Measure: D03 - Members Choosing to Leave the Plan

Title	Description
Label for Stars:	Members Choosing to Leave the Plan (more stars are better because it means fewer members choose to leave the plan)
Label for Data:	Members Choosing to Leave the Plan (lower percentages are better because that indicates fewer members choose to leave the plan)
Description:	Percent of plan members who chose to leave the plan.
Metric:	The percent of members who chose to leave the contract comes from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the contract between January 1, 2022–December 31, 2022 (numerator) divided by all members enrolled in the contract at any time during 2022 (denominator).

Title	Description
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)
Data Source Category:	CMS Administrative Data
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • Contracts with less than 1,000 enrollees • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2022 and 12/31/2022 who disenrolled from the contract with any one of the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan 13 - Disenrollment because of enrollment in another Plan 14 - Retroactive 99 - Other (not supplied by beneficiary). If all potential members in the numerator meet one or more of the exclusion criteria, the measure result will be "Not enough data available". The Disenrollment Reasons Survey (DRS) data available in the HPMS plan preview and in the CMS downloadable Master Table, are not used in the calculation of this measure. The DRS data are presented in each of the systems for information purposes only.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Lower is better
Statistical Method:	Clustering

Title	Description
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00446-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	greater than 41%	greater than 29% to 41%	greater than 18% to 29%	greater than10% to 18%	less than or equal to 10%
PDP	greater than 23%	greater than 17% to 23%	greater than 11% to 17%	greater than 7% to 11%	less than or equal to 7%

Measure: D04 - Drug Plan Quality Improvement

Title	Description
Label for Stars:	Improvement (if any) in the Drug Plan's Performance
Label for Data:	Improvement (If any) in the Drug Plan's Performance
Description:	This shows how much the drug plan's performance has improved or declined from one year to the next year. If a plan receives **1 or 2 stars**, it means, on average, the plan's scores **declined** (got worse). If a plan receives **3 stars**, it means, on average, the plan's scores **stayed about the same**. If a plan receives **4 or 5 stars**, it means, on average, the plan's scores **improved**. Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.
Metric:	The numerator is the net improvement, which is a weighted sum of the number of significantly improved measures minus the number of significantly declined measures.

Title	Description
	The denominator is the sum of the weights associated with the measures eligible for the improvement measure (i.e., the measures that were included in the 2023 and 2024 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2023 and 2024 Star Ratings
Data Source Category:	Star Ratings
Exclusions:	Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.
General Notes:	Attachment I contains the formulas used to calculate the improvement measure and lists indicating which measures were used.
Data Time Frame:	Not Applicable
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Improvement Measure
Weighting Value:	5
Major Disaster:	Includes only measures which have data from both years.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00224-01-C-PARTD
Data Display:	Not Applicable

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than -0.253472	-0.253472 to less than 0	0 to less than 0.193739	0.193739 to less than 0.458889	greater or equal to 0.458889
PDP	less than -0.123026	-0.123026 to less than 0	0 to less than 0.214538	0.214538 to less than 0.401223	greater than or equal to 0.401223

Domain: 3 - Member Experience with the Drug Plan

Measure: D05 - Rating of Drug Plan

Title	Description
Label for Stars:	Members' Rating of Drug Plan
Label for Data:	Members' Rating of Drug Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned from members who rated the prescription drug plan.
Metric:	This case-mix adjusted measure is used to assess members' overall view of their prescription drug plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care

Title	Description

CMIT #: 00641-01-C-PARTD

Data Display: Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	No	Yes	Yes

Base Group Cut Points:

Type	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
MA-PD	less than 84	84 to less than 85	85 to less than 87	87 to less than 89	greater than or equal to 89
PDP	less than 80	80 to less than 81	81 to less than 83	83 to less than 87	greater than or equal to 87

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: D06 - Getting Needed Prescription Drugs

Title	Description

Label for Stars: Ease of Getting Prescriptions Filled When Using the Plan

Label for Data: Ease of Getting Prescriptions Filled When Using the Plan (on a scale from 0 to 100)

Description: Percent of the best possible score the plan earned on how easy it is for members to get the prescription drugs they need using the plan.

Metric: This case-mix adjusted measure is used to assess the ease with which a beneficiary gets the medicines their doctor prescribed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Primary Data Source: CAHPS

Data Source Description: CAHPS Survey Questions (question numbers vary depending on survey type):

- In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
- In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?
- In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?

Data Source Category: Survey of Enrollees

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2023 – 06/2023

General Trend: Higher is better

Title	Description
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00294-01-C-PARTD
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	No	Yes	Yes

Base Group Cut Points:

Type	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
MA-PD	less than 87	87 to less than 89	89 to less than90	90 to less than 91	greater than or equal to 91
PDP	less than 87	87 to less than88	88 to less than 90	90 to less than 91	greater than or equal to 91

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SCAN HEALTH PLAN, *Plaintiff*, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	Case No. 1:23-cv-3910-CJN

JOINT APPENDIX

VOLUME III

Tabs 23 (Pt. 2) – 24

Adjudication Record ("A.R.")

Tab	Document Description	A.R. Page Range
23 (Pt. 2)	CMS's Submission to the Hearing Officer	SCAN-AR00203 – 00411
24	SCAN's Submission to the Hearing Officer	SCAN-AR00422 – 00444

TAB 23
(Part 2)

Domain: 4 - Drug Safety and Accuracy of Drug Pricing

Measure: D07 - MPF Price Accuracy

Title	Description
Label for Stars:	Plan Provides Accurate Drug Pricing Information for This Website
Label for Data:	Plan Provides Accurate Drug Pricing Information for This Website (higher scores are better because they mean more accurate prices)
Description:	A score comparing the drug's total cost at the pharmacy to the drug prices the plan provided for the Medicare Plan Finder website. Higher scores are better because they mean the plan provided more accurate prices.
Metri	This measure evaluates the accuracy of drug prices posted on the MPF tool. A contract's score is based on the accuracy index, or magnitude of difference, and the claim percentage index, or frequency of difference. The accuracy index – or magnitude of difference - considers both ingredient cost and dispensing fee and measures the amount that the PDE price is higher than the MPF price. The claim percentage index – or frequency of difference - also considers both ingredient cost and dispensing fee while measuring how often the PDE price is higher than the MPF price. Therefore, prices that are overstated on MPF will not count against a plan's score. The accuracy index is computed as: (Total amount that PDE is higher than MPF + Total PDE cost) / (Total PDE cost). The claim percentage index is computed as: (Total number of PDEs where PDE cost is higher than MPF) / (Total number of PDEs). The best possible accuracy index is 1 and claim percentage index is 0. Indexes with these values indicate that a plan did not have PDE prices greater than MPF prices. A contract's score is computed using its accuracy index and claim percentage index as: .5 x (100 – ((accuracy index – 1) x 100)) + .5 x ((1 – claim percentage index) x 100).
Primary Data Source:	PDE data, MPF Pricing Files
Data Source Description:	Data used in this measure are obtained from a number of sources: MPF Pricing Files and PDE data are the primary data sources. The PDE data were submitted by drug plans to CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022- September 30, 2022. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the measure. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2022 PDE submission deadline are used to calculate this measure. The HPMS-approved formulary extracts, and data from First DataBank and Medi-span are also used.

Title	Description
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	A contract with less than 30 PDE claims over the measurement period. PDEs must also meet the following criteria: • If the NPI in the Pharmacy Cost (PC) file represents a retail only pharmacy or retail and limited access drug only pharmacy, all corresponding PDEs will be eligible for the measure. However, if the NPI in the PC file represents a retail and other pharmacy type (such as Mail, Home Infusion or Long Term Care pharmacy), only the PDE where the pharmacy service type is identified as either Community/Retail or Managed Care Organization (MCO) will be eligible. • Drug must appear in formulary file and in MPF pricing file • PDE must be a 28-34, 60-62, or 90-93 day supply. If a plan's bid indicates a 1, 2, or 3 month retail days supply amount outside of the 28-34, 60-62, or 90-93 windows, then additional days supply values may be included in the accuracy measure for the plan. • Date of service must occur at a time that data are not suppressed for the plan on MPF • PDE must not be a compound claim • PDE must not be a non-covered drug
General Notes:	Please see Attachment M: Methodology for Price Accuracy Measure for more information about this measure.
Data Time Frame:	01/01/2022 – 09/30/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Affordability and Efficiency
CMIT #:	00452-01-C-PARTD

Title	Description
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 94	94 to less than 96	96 to less than 98	98 to less than 99	greater than or equal to 99
PDP	less than 96	96 to less than 97	97 to less than 98	98 to less than 99	greater than or equal to 99

Measure: D08 - Medication Adherence for Diabetes Medications

Title	Description
Label for Stars:	Taking Diabetes Medication as Directed
Label for Data:	Taking Diabetes Medication as Directed

Description: Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

One of the most important ways people with diabetes can manage their health is by taking their medication as directed. The plan, the doctor, and the member can work together to find ways to do this. ("Diabetes medication" means a *biguanide drug*, a *sulfonylurea drug*, a *thiazolidinedione drug*, a *DPP-4 inhibitor*, a *GLP-1 receptor agonist*, a *meglitinide drug*, or an *SGLT2 inhibitor*. Plan members who take insulin are not included.)

Metric: This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, DiPeptidyl Peptidase (DPP)-4 Inhibitors, GLP-1 receptor agonists, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two fills of diabetes medication(s) on unique dates of service during the measurement period (denominator).

The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their diabetes medication occurs at least 91 days before the end of the enrollment period.

The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA).

See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.

Title	Description
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022-December 31, 2022. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2022 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for diabetes medication(s). PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Encounter Data Systems (EDS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient (IP) and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for insulin
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode.

Title	Description

The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12).

The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by the active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment for IP/SNF stays. Please see Attachment L: Medication Adherence Measure Calculations for more information about these calculation adjustments.

When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.

Data Time Frame: 01/01/2022 – 12/31/2022

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00436-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 80%	80% to less than 84%	84% to less than 88%	88% to less than 90%	greater than or equal to 90%
PDP	less than 84%	84% to less than 87%	87% to less than 89%	89% to less than93%	greater than or equal to 93%

Measure: D09 - Medication Adherence for Hypertension (RAS antagonists)

Title	Description
Label for Stars:	Taking Blood Pressure Medication as Directed
Label for Data:	Taking Blood Pressure Medication as Directed
Description:	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. One of the most important ways people with high blood pressure can manage their health is by taking medication as directed. The plan, the doctor, and the member can work together to do this. ("Blood pressure medication" means an *ACEI (angiotensin converting enzyme inhibitor)*, an *ARB (angiotensin receptor blocker)*, or a *direct renin inhibitor drug*.)
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for RAS antagonist medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two RAS antagonist medication fills on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their RAS antagonist medication occurs at least 91 days before the end of the enrollment period. The Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). See the medication list for this measure. The Part D Medication Adherence rate is calculated using the National Drug Code (NDC) list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022-December 31, 2022. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2022 PDE submission deadline are used to calculate this measure. PDE claims are limited to

Title	Description
	members who received at least two prescriptions on unique dates of service for RAS antagonist medication(s). PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), and the Common Working File (CWF), and the Encounter Data Systems (EDS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for sacubitril/valsartan
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment L: Medication Adherence Measure Calculations for more information about these calculation adjustments.

Title	Description
	When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00437-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 82%	82% to less than 86%	86% to less than 89%	89% to less than 91%	greater than or equal to 91%
PDP	less than 87%	87% to less than 89%	89% to less than 91%	91% to less than 94%	greater than or equal to 94%

Measure: D10 - Medication Adherence for Cholesterol (Statins)

Title	Description
Label for Stars:	Taking Cholesterol Medication as Directed
Label for Data:	Taking Cholesterol Medication as Directed
Description:	Percent of plan members with a prescription for a cholesterol medication (a *statin drug*) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. One of the most important ways people with high cholesterol can manage their health is by taking medication as directed. The plan, the doctor, and the member can work together to do this.
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for statin cholesterol medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for statin cholesterol medication(s) during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two statin cholesterol medication fills on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in the therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their statin medication occurs at least 91 days before the end of the enrollment period. The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022-December 31, 2022. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2022 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for statin medication. PDE adjustments made post-reconciliation were not reflected in this measure.

Title	Description
	Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Encounter Data Systems (EDS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient (IP) and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment L: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2022 – 12/31/2022

Title	Description
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00435-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 82%	82% to less than 86%	86% to less than 88%	88% to less than 91%	greater than or equal to 91%
PDP	less than 84%	84% to less than 87%	87% to less than 89%	89% to less than 93%	greater than or equal to 93%

Measure: D11 - MTM Program Completion Rate for CMR

Title	Description
Label for Stars:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Label for Data:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Description:	Some plan members are in a program (called a *Medication Therapy Management* program) to help them manage their drugs. The measure shows how many members in the program had an assessment of their medications from the plan. The assessment includes a discussion between the member and a pharmacist (or other health care professional) about all of the member's medications. The member also receives a written summary of the discussion, including an action plan that recommends what the member can do to better understand and use his or her medications.

Title	Description
Metric:	This measure is defined as the percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period. Numerator = Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period. Denominator = Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period. Only those beneficiaries who meet the contracts' specified targeting criteria per CMS – Part D requirements pursuant to §423.153(d) of the regulations at any time in the reporting period are included in this measure. Beneficiaries who were in hospice at any point during the reporting period are excluded. Beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time in the measurement year are included in the denominator and the numerator if they received a CMR within this timeframe. Beneficiaries are excluded from the measure calculation if they were enrolled in the contract's MTM program for less than 60 days and did not receive a CMR within this timeframe. The date of enrollment is counted towards the 60 days but the opt-out date is not. A beneficiary's MTM eligibility, receipt of CMRs, etc., is determined for each contract he/she was enrolled in during the measurement period. Similarly, a contract's CMR completion rate is calculated based on each of its eligible MTM enrolled beneficiaries. For example, a beneficiary must meet the inclusion criteria for the contract to be included in the contract's CMR rate. A beneficiary who is enrolled in two different contracts' MTM programs for 30 days each is therefore excluded from both contracts' CMR rates. The beneficiary is only included in the measure calculation for the contract(s) where they were enrolled at least 60 days. Beneficiaries with multiple records that contain varying information for the same contract are excluded from the measure calculation for that contract. Beneficiaries may be enrolled in MTM based on the contracts' specified targeting criteria per CMS – Part D requirements and/or based on expanded, other plan-specific targeting criteria. Beneficiaries who were initially enrolled in MTM due to other plan-specific (expanded) criteria and then later met the contracts' specified targeting criteria per CMS – Part D requirements at any time in the reporting period are included in this measure. In these cases, a CMR received after the date of MTM enrollment but before the date the beneficiary met the specified targeting criteria per CMS – Part D requirements are included.
Primary Data Source:	Part D Plan Reporting
Data Source Description:	The data for this measure were reported by contracts to CMS per the 2022 Part D Reporting Requirements (data pulled June 2023). Validation of these data was performed retrospectively during the 2023 data validation cycle (deadline June 30, 2023 and data validation results pulled July 2023). Additionally, the Medicare Enrollment Database (EDB) is used for hospice enrollment (data pulled March 2023).
Data Source Category:	Health and Drug Plans

Title	Description
Exclusions:	Contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2023) are excluded and listed as "No data available." MTM CMR rates are not provided for contracts that did not score at least 95% on data validation for the Medication Therapy Management Program reporting section or were not compliant with data validation standards/sub-standards for any of the following Medication Therapy Management Program data elements. We define a contract as being non-complaint if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation. • MBI Number (Element B) • Date of MTM program enrollment (Element H) • Met the specified targeting criteria per CMS – Part D requirements (Element F) • Date met the specified targeting criteria per CMS – Part D requirements (Element J) • Date of MTM program opt-out, if applicable (Element K) • Received annual CMR with written summary in CMS standardized format (Element O) • Date(s) of CMR(s) (Element P) MTM CMR rates are also not provided for contracts that failed to submit their MTM file and pass system validation by the reporting deadline or who had a missing data validation score for MTM. Contracts excluded from the MTM CMR Rates due to data validation issues are shown as "CMS identified issues with this plan's data." See Attachment N for more details on the MTM CMR completion rate measure scoring methodology. Contracts can view their data validation results in HPMS (https://hpms.cms.gov/). To access this page, from the top menu select "Monitoring," then "Plan Reporting Data Validation." Select the appropriate contract year. Select the PRDVM Reports. Select "Score Detail Report." Select the applicable reporting section. If you cannot see the Plan Reporting Data Validation module, contact CMS at HPMS_Access@cms.hhs.gov. Additionally, contracts must have 31 or more enrollees in the denominator in order to have a calculated rate. Contracts with fewer than 31 eligible enrollees are listed as "Not enough data available".
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included

Title	Description
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00454-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 67%	67% to less than 77%	77% to less than 85%	85% to less than 92%	greater than or equal to 92%
PDP	less than 34%	34% to less than 52%	52% to less than 63%	63% to less than 77%	greater than or equal to 77%

Measure: D12 - Statin Use in Persons with Diabetes (SUPD)

Title	Description
Label for Stars:	The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol
Label for Data:	The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol
Description:	To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of plan members with diabetes who take the most effective cholesterol-lowering drugs. Plans can help make sure their members get these prescriptions filled.
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills on unique dates of service and received a statin medication fill during the measurement period. The percentage is calculated as the number of member-years of enrolled beneficiaries 40-75 years old who received a statin medication fill during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 40-75 years old with at least two diabetes medication fills on unique dates of service during the measurement period (denominator). Beneficiaries are only included in the measure calculation if the first fill of their diabetes medication occurs at least 90 days before the end of the measurement year or end of the enrollment episode.

Title	Description
	The SUPD measure is adapted from the measure concept that was developed and endorsed by the Pharmacy Quality Alliance (PQA). See the medication list for this measure. The SUPD measure is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists, including diagnosis codes, are posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from Prescription Drug Event (PDE) data submitted by drug plans to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022 – December 31, 2022. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2022 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Encounter Data Systems (EDS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes. • EDS is used to identify diagnoses based on ICD-10-CM codes.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates • Rhabdomyolysis and myopathy • Pregnancy • Lactation and fertility • Cirrhosis • Pre-Diabetes • Polycystic Ovary Syndrome

Title	Description

General Notes: Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode.

The measure is weighted based on the total number of member years for each episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12).

Data Time Frame: 01/01/2022 – 12/31/2022

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00702-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 81%	81% to less than 86%	86% to less than 88%	88% to less than 92%	greater than or equal to 92%
PDP	less than 81%	81% to less than 83%	83% to less than 85%	85% to less than 87%	greater than or equal to 87%

Attachment A: CAHPS Case-Mix Adjustment

CAHPS Case-Mix Adjustment

The CAHPS measures are case-mix adjusted to take into account the mix of enrollees. Case-mix variables include administrative age, dual eligibility status, low-income subsidy (LIS) indicator, and use of Asian language survey, and self-reported education, general health status, mental health status, and proxy usage status. The tables below include the case-mix variables and show the case-mix coefficients for each of the CAHPS measures included in the Star Ratings. The coefficients indicate how much higher or lower people with a given characteristic tend to respond compared to otherwise similar people with the baseline value for that characteristic (e.g., reference group), on the original scale of the item or composite, as presented in plan reports. The reference group for each characteristic will have a coefficient value of zero.

For example, for the measure "Rating of Health Care Quality," the model coefficient for "age 75-79" is 0.0521, indicating that respondents in that age range tend to score their plans 0.0521 points higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, Medicaid dual eligibles tend to respond 0.0322 points lower on this item than otherwise similar non-duals. Contracts with higher proportions of beneficiaries who are in the 75-79 age range will be adjusted downward on this measure to compensate for the positive response tendency of their respondents. Similarly, contracts with higher proportions of respondents who are Medicaid dual eligibles will be adjusted upward on this measure to compensate for their respondents' negative response tendency. The case-mix patterns are not always consistent across measures. Missing case-mix adjustors are imputed as the contract mean.

The composites consist of multiple items, each of which is adjusted separately before combining the adjusted scores into a composite score. Item-level coefficients are presented below separately for each composite. For more detailed information on the application of CAHPS case-mix adjustment, please review the materials at https://ma-pdpcahps.org/en/scoring-and-star-ratings/.

Table A-1: Coefficients of Part C Getting Needed Care (C19) CAHPS Measure Composite Items

Predictor	Get Appointment with Specialist	Easy to Get Care
Age: 64 or under	0.0414	-0.0138
Age: 65 – 69	0.0069	-0.0144
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.0241	-0.0047
Age: 80 – 84	0.0101	0.0030
Age: 85 and older	0.0122	-0.0184
Less than an 8th grade education	0.0147	-0.0513
Some high school	0.0152	0.0390
High school graduate	0.0000	0.0000
Some college	-0.0174	-0.0368
College graduate	-0.0451	-0.0436
More than a bachelor's degree	-0.0861	-0.0641
General health rating: excellent	0.1082	0.0313
General health rating: very good	0.0623	0.0552
General health rating: good	0.0000	0.0000
General health rating: fair	-0.0744	-0.0488
General health rating: poor	-0.0956	-0.1716
Mental health rating: excellent	0.1989	0.2116
Mental health rating: very good	0.0973	0.1005
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.0560	-0.0609
Mental health rating: poor	-0.0956	-0.1199
Proxy helped	0.0318	0.0089
Proxy answered	0.0170	0.0893
Medicaid dual eligible	0.0019	-0.0222
Low-income subsidy (LIS)	0.0088	-0.0506
Asian survey language	0.0527	-0.1072

Table A-2: Coefficients of Part C Getting Appointments and Care Quickly (C20) CAHPS Measure Composite Items

Predictor	Getting Needed Care as Soon as Wanted	Getting Routine Care as Soon as Wanted	Wait Less Than 15 Minutes
Age: 64 or under	-0.0044	0.0542	-0.0653
Age: 65 – 69	0.0333	0.0009	-0.0177
Age: 70 – 74	0.0000	0.0000	0.0000
Age: 75 – 79	0.0401	0.0218	0.0122
Age: 80 – 84	0.0326	0.0389	-0.0077
Age: 85 and older	0.0710	0.0243	0.0141
Less than an 8th grade education	0.0230	-0.0306	-0.0526
Some high school	0.0125	-0.0357	0.0548
High school graduate	0.0000	0.0000	0.0000
Some college	0.0023	-0.0203	0.0344
College graduate	0.0086	-0.0511	0.0225
More than a bachelor's degree	-0.0137	-0.0717	0.0122
General health rating: excellent	0.1011	0.0186	0.2354
General health rating: very good	0.0425	0.0092	0.0974
General health rating: good	0.0000	0.0000	0.0000
General health rating: fair	-0.0476	-0.0439	-0.0891
General health rating: poor	-0.0857	-0.0784	-0.1452
Mental health rating: excellent	0.1801	0.1525	0.1130
Mental health rating: very good	0.0698	0.0749	0.0421
Mental health rating: good	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0306	-0.0406	-0.0215
Mental health rating: poor	-0.0917	-0.0721	0.0829
Proxy helped	0.0512	-0.0061	-0.0675
Proxy answered	0.0764	0.0762	-0.0235
Medicaid dual eligible	-0.0436	-0.0336	-0.0196
Low-income subsidy (LIS)	0.0031	-0.0299	0.0143
Asian survey language	-0.2210	-0.2959	-0.0893

Table A-3: Coefficients of Part C Customer Service (C21) CAHPS Measure Composite Items

Predictor	Paperwork Easy	Plan Customer Service Gives Information	Plan Customer Service Courtesy and Respect
Age: 64 or under	0.0170	0.0369	-0.0096
Age: 65 – 69	0.0067	0.0112	-0.0096
Age: 70 – 74	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0082	0.0074	-0.0132
Age: 80 – 84	-0.0240	-0.0097	-0.0201
Age: 85 and older	-0.0152	0.0039	0.0036
Less than an 8th grade education	-0.0299	-0.0156	-0.0191
Some high school	-0.0184	-0.0061	-0.0111
High school graduate	0.0000	0.0000	0.0000
Some college	-0.0084	-0.0679	-0.0218
College graduate	-0.0151	-0.0890	-0.0221
More than a bachelor's degree	-0.0392	-0.1450	-0.0353
General health rating: excellent	0.0196	0.0352	0.0266
General health rating: very good	0.0082	0.0461	0.0116
General health rating: good	0.0000	0.0000	0.0000
General health rating: fair	-0.0249	-0.0314	0.0039
General health rating: poor	-0.0321	-0.0346	-0.0327
Mental health rating: excellent	0.0611	0.1837	0.0895
Mental health rating: very good	0.0350	0.0735	0.0397
Mental health rating: good	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0372	-0.0363	-0.0244
Mental health rating: poor	-0.0980	-0.1784	-0.1015
Proxy helped	-0.0749	0.0000	-0.0225
Proxy answered	0.0045	0.0391	0.0029
Medicaid dual eligible	-0.0658	0.0405	-0.0137
Low-income subsidy (LIS)	0.0063	0.0068	0.0222
Asian survey language	-0.1493	-0.0986	-0.1499

Table A-4: Coefficients of Part C Stand-alone CAHPS Measures

Predictor	Paperwork Easy	Plan Customer Service Gives Information	Plan Customer Service Courtesy and Respect
Age: 64 or under	0.0170	0.0369	-0.0096
Age: 65 – 69	0.0067	0.0112	-0.0096
Age: 70 – 74	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0082	0.0074	-0.0132
Age: 80 – 84	-0.0240	-0.0097	-0.0201
Age: 85 and older	-0.0152	0.0039	0.0036
Less than an 8th grade education	-0.0299	-0.0156	-0.0191
Some high school	-0.0184	-0.0061	-0.0111
High school graduate	0.0000	0.0000	0.0000
Some college	-0.0084	-0.0679	-0.0218
College graduate	-0.0151	-0.0890	-0.0221
More than a bachelor's degree	-0.0392	-0.1450	-0.0353
General health rating: excellent	0.0196	0.0352	0.0266
General health rating: very good	0.0082	0.0461	0.0116
General health rating: good	0.0000	0.0000	0.0000
General health rating: fair	-0.0249	-0.0314	0.0039
General health rating: poor	-0.0321	-0.0346	-0.0327
Mental health rating: excellent	0.0611	0.1837	0.0895
Mental health rating: very good	0.0350	0.0735	0.0397
Mental health rating: good	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0372	-0.0363	-0.0244
Mental health rating: poor	-0.0980	-0.1784	-0.1015
Proxy helped	-0.0749	0.0000	-0.0225
Proxy answered	0.0045	0.0391	0.0029
Medicaid dual eligible	-0.0658	0.0405	-0.0137
Low-income subsidy (LIS)	0.0063	0.0068	0.0222
Asian survey language	-0.1493	-0.0986	-0.1499

Table A-5: Coefficients of Part C Care Coordination (C24) CAHPS Measure Composite Items

Predictor	MD/Office Help to Manage Care	MD Informed About Specialist Care	MD Follows up about Test Results and Gives Results as soon as Needed	Talk with MD about Medicines	MD has Medical Records about Care
Age: 64 or under	0.0046	-0.0114	-0.0013	0.0402	-0.0265
Age: 65 – 69	-0.0528	-0.0120	-0.0077	0.0376	-0.0073
Age: 70 – 74	0.0000	0.0000	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0282	0.0151	-0.0080	-0.0344	0.0022
Age: 80 – 84	-0.0190	0.0006	0.0066	-0.1098	-0.0094
Age: 85 and older	-0.0895	-0.0232	-0.0263	-0.1662	-0.0021
Less than an 8th grade education	0.0260	0.1001	-0.0047	0.0194	-0.0268
Some high school	-0.0135	0.0669	0.0250	-0.0074	-0.0330
High school graduate	0.0000	0.0000	0.0000	0.0000	0.0000
Some college	-0.0034	-0.0245	-0.0377	-0.0035	-0.0055
College graduate	-0.0332	-0.0389	-0.0417	-0.0222	-0.0205
More than a bachelor's degree	-0.0216	-0.0856	-0.0365	-0.0587	-0.0065
General health rating: excellent	-0.0008	-0.0270	0.0860	0.1207	-0.0079
General health rating: very good	-0.0111	-0.0040	0.0423	0.0601	0.0247
General health rating: good	0.0000	0.0000	0.0000	0.0000	0.0000
General health rating: fair	-0.0650	-0.0502	-0.0636	-0.0435	-0.0308
General health rating: poor	-0.1020	-0.1222	-0.1524	-0.1039	-0.0726
Mental health rating: excellent	0.1224	0.1946	0.1645	0.1768	0.0931
Mental health rating: very good	0.0304	0.0808	0.0931	0.0867	0.0571
Mental health rating: good	0.0000	0.0000	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0391	-0.1002	-0.0407	-0.0597	-0.0274
Mental health rating: poor	-0.0342	-0.1422	-0.0559	-0.0531	-0.0843
Proxy helped	0.0196	-0.0021	-0.0019	0.0816	-0.0079
Proxy answered	-0.0020	-0.0433	0.0655	0.0710	0.0457
Medicaid dual eligible	-0.0061	0.0613	-0.0082	0.0014	-0.0122
Low-income subsidy (LIS)	-0.0318	0.1438	0.0131	-0.0131	0.0067
Asian survey language	0.1027	-0.1596	0.1903	-0.1308	-0.1026

Table A-6: Coefficients of Part D CAHPS Stand-alone Measures

Predictor	MA-PD D05: Rating of Drug Plan	PDP D05: Rating of Drug Plan
Age: 64 or under	-0.1891	-0.3770
Age: 65 – 69	-0.1095	-0.1195
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.1042	0.1631
Age: 80 – 84	0.1505	0.2597
Age: 85 and older	0.1974	0.5198
Less than an 8th grade education	0.0703	-0.1769
Some high school	0.0425	0.0060
High school graduate	0.0000	0.0000
Some college	-0.2087	-0.3485
College graduate	-0.3306	-0.1539
More than a bachelor's degree	-0.4426	-0.5077
General health rating: excellent	0.2238	0.1233
General health rating: very good	0.1922	0.0239
General health rating: good	0.0000	0.0000
General health rating: fair	-0.1861	-0.2132
General health rating: poor	-0.4147	-0.3450
Mental health rating: excellent	0.3268	0.1120
Mental health rating: very good	0.1035	0.0617
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.1101	-0.2242
Mental health rating: poor	-0.1847	-0.9212
Proxy helped	-0.1628	-0.2064
Proxy answered	-0.0284	0.2563
Medicaid dual eligible	0.3942	0.8442
Low-income subsidy (LIS)	0.3567	0.5929
Asian survey language	-0.3631	0.0000

Table A-7: Coefficients of Part D Getting Needed Prescription Drugs (D06) CAHPS Measure Composite Items

Predictor	MA-PD: Get Needed Prescription Drugs	MA-PD: Get Prescription Drugs from Mail or Pharmacy	PDP: Get Needed Prescription Drugs	PDP: Get Prescription Drugs from Mail or Pharmacy
Age: 64 or under	-0.0603	-0.0276	-0.1955	-0.1288
Age: 65 – 69	-0.0152	-0.0062	-0.0411	-0.0108
Age: 70 – 74	0.0000	0.0000	0.0000	0.0000
Age: 75 – 79	0.0204	0.0136	0.0322	0.0381
Age: 80 – 84	0.0462	0.0168	0.0365	0.0418
Age: 85 and older	0.0138	-0.0005	0.0134	-0.0303
Less than an 8th grade education	-0.0556	-0.0378	-0.0470	-0.0335
Some high school	-0.0062	-0.0187	-0.1264	-0.1132
High school graduate	0.0000	0.0000	0.0000	0.0000
Some college	-0.0375	-0.0425	-0.0692	-0.0427
College graduate	-0.0481	-0.0536	-0.0365	-0.0626
More than a bachelor's degree	-0.0618	-0.0857	-0.1088	-0.1149
General health rating: excellent	0.0306	0.0614	0.0839	0.0712
General health rating: very good	0.0473	0.0425	0.0331	0.0552
General health rating: good	0.0000	0.0000	0.0000	0.0000
General health rating: fair	-0.0529	-0.0442	-0.1217	-0.0695
General health rating: poor	-0.1323	-0.1428	-0.2777	-0.1987
Mental health rating: excellent	0.0988	0.1109	-0.0206	0.0334
Mental health rating: very good	0.0502	0.0555	-0.0026	0.0256
Mental health rating: good	0.0000	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0506	-0.0467	-0.1631	-0.0679
Mental health rating: poor	-0.0532	-0.0254	-0.3480	-0.2465
Proxy helped	-0.0094	0.0049	-0.0014	-0.0612
Proxy answered	0.0294	0.0411	0.1625	0.0613
Medicaid dual eligible	0.0413	0.0149	0.0288	0.0656
Low-income subsidy (LIS)	0.0689	0.0170	0.1885	0.1608
Asian survey language	-0.0583	0.0220	0.0000	0.0000

Attachment B: Calculating Measure Data for the Surviving Contract of a Consolidation

First Year Following a Consolidation

In the first year following a consolidation, the measure values for the surviving contract of a consolidation are calculated as the enrollment-weighted mean of all contracts in the consolidation. The month(s) of enrollment used to calculate the enrollment weighted means varies by the type measure. Table B-1 below lists the enrollment used for each type of measure and the rule followed to determine the month(s) of enrollment. Table B-2 provides an example calculation.

Table B-1: Enrollment Month Used in Calculating Measure Scores for the Surviving Contract of a Consolidation

Type of Measure	Rule for Which Month of Enrollment is Used	Month(s) of Enrollment Used for 2024 Star Ratings
CAHPS	Enrollment at the time survey sample is pulled	January 2023
Call Center	Average enrollment during the study period	Feb 2023 – May 2023
HOS	Enrollment at the time survey sample is pulled	April 2022
HEDIS-HOS	Enrollment at the time survey sample is pulled	April 2022
HEDIS	Enrollment in July of the measurement period	July 2022
All Other Measures	Enrollment in July of the measurement period	July 2022

Table B-2: Example of Calculating the Measure Score for the Surviving Contract of a Consolidation

Contract ID	Surviving or Consumed Contract	Value for Breast Cancer Screening (BCS) Measure	July 2022 Enrollment
HAAAA	Surviving	75.13	43,326
HAAAB	Consumed	50.91	20,933

$$\text{Value for BCS for HAAAA} = \frac{75.13*43,326+50.91*20,933}{43,326+20,933} = 67.24$$

Second Year Following a Consolidation

In the second year following a consolidation, the measure values for the surviving contract of a consolidation are as reported for CAHPS, call center, HOS, and HEDIS measures. For all other measures, the measure values for the surviving contract of a consolidation are calculated as the enrollment weighted mean of all contracts in the consolidation.

Attachment C: National Averages for Part C and D Measures

The tables below contain the average of the average of contract numeric and star values for each measure reported in the 2024 Star Ratings. The averages are calculated after the disaster adjustment has been applied.

Table C-1: National Averages for Part C Measures

Measure ID	Measure Name	Numeric Average	Star Average
C01	Breast Cancer Screening	72%	3.7
C02	Colorectal Cancer Screening	71%	3.7
C03	Annual Flu Vaccine	72%	3.1
C04	Monitoring Physical Activity	50%	3.0
C05	Special Needs Plan (SNP) Care Management	72%	3.4
C06	Care for Older Adults – Medication Review	91%	3.8
C07	Care for Older Adults – Pain Assessment	91%	3.9
C08	Osteoporosis Management in Women who had a Fracture	44%	2.6
C09	Diabetes Care – Eye Exam	72%	3.5
C10	Diabetes Care – Blood Sugar Controlled	79%	3.6
C11	Controlling Blood Pressure	73%	3.4
C12	Reducing the Risk of Falling	56%	2.9
C13	Improving Bladder Control	45%	3.2
C14	Medication Reconciliation Post-Discharge	65%	3.4
C15	Plan All-Cause Readmissions	11%	2.9
C16	Statin Therapy for Patients with Cardiovascular Disease	85%	3.3
C17	Transitions of Care	51%	2.5
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	56%	3.0
C19	Getting Needed Care	80	3.4
C20	Getting Appointments and Care Quickly	77	3.5
C21	Customer Service	90	3.6
C22	Rating of Health Care Quality	86	3.3
C23	Rating of Health Plan	87	3.1
C24	Care Coordination	86	3.6
C25	Complaints about the Health Plan	0.32	3.9
C26	Members Choosing to Leave the Plan	19%	3.6
C27	Health Plan Quality Improvement	Medicare only shows a Star Rating for this topic	3.0
C28	Plan Makes Timely Decisions about Appeals	94%	4.1
C29	Reviewing Appeals Decisions	95%	3.6
C30	Call Center – Foreign Language Interpreter and TTY Availability	93%	4.3

Table C-2: National Averages for Part D Measures

Measure ID	Measure Name	MA-PD Numeric Average	MA-PD Star Average	PDP Numeric Average	PDP Star Average
D01	Call Center – Foreign Language Interpreter and TTY Availability	94%	3.7	94%	3.0
D02	Complaints about the Drug Plan	0.33	3.9	0.05	3.9
D03	Members Choosing to Leave the Plan	19%	3.6	12%	3.8
D04	Drug Plan Quality Improvement	Medicare only shows a Star Rating for this topic	3.4	Medicare only shows a Star Rating for this topic	2.9
D05	Rating of Drug Plan	87	3.2	83	3.4
D06	Getting Needed Prescription Drugs	90	3.5	89	3.5
D07	MPF Price Accuracy	97	3.6	97	3.6
D08	Medication Adherence for Diabetes Medications	86%	3.3	86%	2.6
D09	Medication Adherence for Hypertension (RAS antagonists)	88%	3.4	89%	2.6
D10	Medication Adherence for Cholesterol (Statins)	87%	3.2	87%	3.0
D11	MTM Program Completion Rate for CMR	84%	3.5	56%	3.2
D12	Statin Use in Persons with Diabetes (SUPD)	85%	2.7	82%	2.4

Attachment D: Part C and D Data Time Frames

Table D-1: Part C Measure Data Time Frames

Measure ID	Measure Name	Primary Data Source	Data Time Frame
C01	Breast Cancer Screening	HEDIS	01/01/2022 – 12/31/2022
C02	Colorectal Cancer Screening	HEDIS	01/01/2022 – 12/31/2022
C03	Annual Flu Vaccine	CAHPS	03/2023 – 06/2023
C04	Monitoring Physical Activity	HEDIS-HOS	07/19/2022 – 11/01/2022
C05	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	01/01/2022 – 12/31/2022
C06	Care for Older Adults – Medication Review	HEDIS	01/01/2022 – 12/31/2022
C07	Care for Older Adults – Pain Assessment	HEDIS	01/01/2022 – 12/31/2022
C08	Osteoporosis Management in Women who had a Fracture	HEDIS	01/01/2022 – 12/31/2022
C09	Diabetes Care – Eye Exam	HEDIS	01/01/2022 – 12/31/2022
C10	Diabetes Care – Blood Sugar Controlled	HEDIS	01/01/2022 – 12/31/2022
C11	Controlling Blood Pressure	HEDIS	01/01/2022 – 12/31/2022
C12	Reducing the Risk of Falling	HEDIS-HOS	07/19/2022 – 11/01/2022
C13	Improving Bladder Control	HEDIS-HOS	07/19/2022 – 11/01/2022
C14	Medication Reconciliation Post-Discharge	HEDIS	01/01/2022 – 12/31/2022
C15	Plan All-Cause Readmission	HEDIS	01/01/2022 – 12/31/2022
C16	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	01/01/2022 – 12/31/2022
C17	Transitions of Care	HEDIS	01/01/2022 – 12/31/2022
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS	01/01/2022 – 12/31/2022
C19	Getting Needed Care	CAHPS	03/2023 – 06/2023
C20	Getting Appointments and Care Quickly	CAHPS	03/2023 – 06/2023
C21	Customer Service	CAHPS	03/2023 – 06/2023
C22	Rating of Health Care Quality	CAHPS	03/2023 – 06/2023
C23	Rating of Health Plan	CAHPS	03/2023 – 06/2023
C24	Care Coordination	CAHPS	03/2023 – 06/2023
C25	Complaints about the Health Plan	Complaints Tracking Module (CTM)	01/01/2022 – 12/31/2022
C26	Members Choosing to Leave the Plan	MBDSS	01/01/2022 – 12/31/2022
C27	Health Plan Quality Improvement	Star Ratings	Not Applicable
C28	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE)	01/01/2022 – 12/31/2022
C29	Reviewing Appeals Decisions	Independent Review Entity (IRE)	01/01/2022 – 12/31/2022
C30	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	02/2023 – 05/2023

Table D-2: Part D Measure Data Time Frames

Measure ID	Measure Name	Primary Data Source	Data Time Frame
D01	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	02/2023 – 05/2023
D02	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	01/01/2022 – 12/31/2022
D03	Members Choosing to Leave the Plan	MBDSS	01/01/2022 – 12/31/2022
D04	Drug Plan Quality Improvement	Star Ratings	Not Applicable
D05	Rating of Drug Plan	CAHPS	03/2023 – 06/2023
D06	Getting Needed Prescription Drugs	CAHPS	03/2023 – 06/2023
D07	MPF Price Accuracy	PDE data, MPF Pricing Files	01/01/2022 – 09/30/2022
D08	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) data	01/01/2022 – 12/31/2022
D09	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) data	01/01/2022 – 12/31/2022
D10	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) data	01/01/2022 – 12/31/2022
D11	MTM Program Completion Rate for CMR	Part D Plan Reporting	01/01/2022 – 12/31/2022
D12	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) data	01/01/2022 – 12/31/2022

1. Medicare Part C Reporting Requirements Measure (C05: SNP Care Management)

Step 1: Start with all contracts that offer at least one SNP plan that was active at any point during contract year 2022.

Step 2: Exclude any contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2023), or that were not required to participate in data validation. This exclusion is consistent with the statement from page 6 of the CY 2022 Medicare Part C Plan Reporting Requirements Technical Specifications Document: "**Note:** If a contract terminates before July 1 in the following year after the contract year (CY) reporting period, the contract is not required to report any data for the respective two years – the CY reporting period, and the following year… If a PBP (Plan) under a contract terminates at any time in the CY reporting period and the contract remains active through July 1 of the following year, the contract must still report data for all PBPs, including the terminated PBP."

This excludes:

- Contracts that terminate on or before 07/01/2023 according to the Contract Info extract

Step 3: After removing contract data excluded above, suppress contract rates based on the following rules:

Section-level DV failure: Contracts that score less than 95% in DV for their CY 2022 SNP Care Reporting Requirements data are listed as "CMS identified issues with this plan's data."

Element-level DV failure: Contracts that score 95% or higher in DV for their CY 2022 SNP Care Reporting Requirements data but that failed at least one of the four data elements (elements A, B, C, and F) are listed as "CMS identified issues with this plan's data."

Small size: Contracts that have not yet been suppressed and have a SNP Care Assessment rate denominator [Number of New Enrollees due for an Initial HRA (Element A) + Number of enrollees eligible for an annual reassessment HRA (Element B)] of fewer than 30 are listed as "No Data Available."

Organizations can view their own plan reporting data validation results in HPMS (https://hpms.cms.gov/). From the home page, select Monitoring | Plan Reporting Data Validation.

Step 4: Calculate the rate for the remaining contract using the formula:

[Number of initial HRAs performed on new enrollees (Element C)

+ Number of annual reassessments performed on enrollees eligible for a reassessment (Element F)]

/ [Number of new enrollees due for an Initial HRA (Element A)

+ Number of enrollees eligible for an annual reassessment HRA (Element B)]

2. NCQA HEDIS Measures - (C06 – C07: Care for Older Adults)

The example NCQA measure combining methodology specifications below are written for two Plan Benefit Package (PBP) submissions, which we distinguish as 1 and 2, but the methodology easily extends to any number of submissions.

Rates are produced for any contract offering a SNP in the ratings year which provided SNP HEDIS data in the measurement year.

Definitions

Let N_1 = The Total Number of Members Eligible for the HEDIS measure in the first PBP ("fixed" and auditable)

Let N_2 = The Total Number of Members Eligible for the HEDIS measure in the second PBP ("fixed" and auditable)

Let P_1 = The estimated rate (mean) for the HEDIS measure in the first PBP (auditable)

Let P_2 = The estimated rate (mean) for the same HEDIS measure in the second PBP (auditable)

Setup Calculations

Based on the above definitions, there are two additional calculations:

Let W_1 = The weight assigned to the first PBP results (estimated, auditable). This is estimated from the formula $W_1 = N_1 / (N_1 + N_2)$

Let W_2 = The weight assigned to the second PBP results (estimated, auditable). This is estimated from the formula $W_2 = N_2 / (N_1 + N_2)$

Pooled Analysis

The pooled result from the two rates (means) is calculated as: $P_{pooled} = W_1 * P_1 + W_2 * P_2$

NOTES:
Weights are based on the eligible member population. While it may be more accurate to remove all excluded members before weighting, NCQA and CMS have chosen not to do this (to simplify the method) for two reasons: 1) the number of exclusions relative to the size of the population should be small, and 2) exclusion rates (as a percentage of the eligible population) should be similar for each PBP and negligibly affect the weights.

If one or more of the submissions has a status of NA, those submissions are dropped and not included in the weighted rate (mean) calculations. If one or more of the submissions has an audit designation of BR or NR (which has been determined to be biased or is not reported by choice of the contract), the rate is set to zero as detailed in the section titled "Handling of Biased, Erroneous and/or Not Reportable (NR) Data" and the average enrollment for the year is used for the eligible population in the PBP. An example is shown in table E-1.

Table E-1: Example Calculation Using Effectiveness of Care Rate

Numeric Example Using an Effectiveness of Care Rate	
# of Total Members Eligible for the HEDIS measure in PBP 1, N_1 =	1500
# of Total Members Eligible for the HEDIS measure in PBP 2, N_2 =	2500
HEDIS Result for PBP 1, Enter as a Proportion between 0 and 1, P_1 =	0.75
HEDIS Result for PBP 2, Enter as a Proportion between 0 and 1, P_2 =	0.5
Setup Calculations - Initialize Some Intermediate Results	
The weight for PBP 1 product estimated by $W_1 = N_1 / (N_1 + N_2)$	0.375
The weight for PBP 2 product estimated by $W_2 = N_2 / (N_1 + N_2)$	0.625
Pooled Results	
$P_{pooled} = W_1 * P_1 + W_2 * P_2$	0.59375

Attachment F: Calculating Measure C15: Plan All-Cause Readmissions

All data are available in the CMS 2023 HEDIS® Public Use File (PUF)[1] and can be looked up by IndicatorKey (row) and Variable name (column).

The calculations below use the Denominator, ObservedCount and ExpectedCount values from the PCR (18-64) indicator (IndicatorKey = 202025_20) and the PCR (65+) indicator (IndicatorKey = 202111_20).

For each contract, calculate the (18+) Denominator, ObservedCount, and ExpectedCount:

Denominator(18+) = Denominator(18-64) + Denominator(65+)
ObservedCount(18+) = ObservedCount(18-64) + ObservedCount(65+)
ExpectedCount(18+) = ExpectedCount(18-64) + ExpectedCount(65+)

Using these (18+) values, calculate the (18+) Observed-over-Expected ratio (OE):

$$OE(18+) = \left(\frac{ObservedCount(18+)}{ExpectedCount(18+)}\right)$$

And the national average of the (18+) Observed Rate:

$$NatAvgObs(18+) = Average\left(\left(\frac{ObservedCount(18+)_1}{Denominator(18+)_1}\right) + \ldots + \left(\frac{ObservedCount(18+)_n}{Denominator(18+)_n}\right)\right)$$

Where 1 through n are all contracts with a (18+) Denominator larger than or equal to 150, and a (18+) OE larger than or equal to 0.2 and less than or equal to 5.0.
For each contract, calculate the Final Rate and convert to percentages:

Final Rate(18+) = OE(18+) x NatAvgObs(18+) x 100

And round to the nearest integer.

Example: Calculating the final rate for Contract 1

Contract	Indicator Key	Denominator	Observed Count	Expected Count
Contract 1	202025_20	214	8	12
Contract 1	202111_20	4,792	641	642
Contract 2	202025_20	225	12	7
Contract 2	202111_20	4,761	688	668
Contract 3	202025_20	573	31	35
Contract 3	202111_20	8,629	1,126	1,070
Contract 4	202025_20	12	0	1
Contract 4	202111_20	533	79	73

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-HEDIS-Public-Use-Files

$$\text{NatAvgObs} = \text{Average}\left(\left(\frac{8+641}{214+4,792}\right) + \left(\frac{12+688}{225+4,761}\right) + \left(\frac{31+1,126}{573+8,629}\right) + \left(\frac{0+79}{12+533}\right)\right)$$

$$\text{NatAvgObs} = 0.135181$$

$$\text{OE Contract 1} = \left(\frac{8+641}{12+642}\right) = 0.992355$$

$$\text{Final Rate Contract 1} = 0.992355 \times 0.135181 \times 100 = 13.41$$

Final Rate reported for Contract 1 = 13%

The actual calculated National Observed Rate used in the 2024 Star Ratings was 0.109719901931738.

Attachment G: Weights Assigned to Individual Performance Measures

Table G-1: Part C Measure Weights

Measure ID	Measure Name	Weighting Category	Part C Summary and MA-PD Overall
C01	Breast Cancer Screening	Process Measure	1
C02	Colorectal Cancer Screening	Process Measure	1
C03	Annual Flu Vaccine	Process Measure	1
C04	Monitoring Physical Activity	Process Measure	1
C05	Special Needs Plan (SNP) Care Management	Process Measure	1
C06	Care for Older Adults – Medication Review	Process Measure	1
C07	Care for Older Adults – Pain Assessment	Process Measure	1
C08	Osteoporosis Management in Women who had a Fracture	Process Measure	1
C09	Diabetes Care – Eye Exam	Process Measure	1
C10	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3
C11	Controlling Blood Pressure	Intermediate Outcome Measure	3
C12	Reducing the Risk of Falling	Process Measure	1
C13	Improving Bladder Control	Process Measure	1
C14	Medication Reconciliation Post-Discharge	Process Measure	1
C15	Plan All-Cause Readmissions	Outcome Measure	1*
C16	Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1
C17	Transitions of Care	Process Measure	1
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Process Measure	1
C19	Getting Needed Care	Patients' Experience and Complaints Measure	4
C20	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	4
C21	Customer Service	Patients' Experience and Complaints Measure	4
C22	Rating of Health Care Quality	Patients' Experience and Complaints Measure	4
C23	Rating of Health Plan	Patients' Experience and Complaints Measure	4
C24	Care Coordination	Patients' Experience and Complaints Measure	4

Measure ID	Measure Name	Weighting Category	Part C Summary and MA-PD Overall
C25	Complaints about the Health Plan	Patients' Experience and Complaints Measure	4
C26	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	4
C27	Health Plan Quality Improvement	Improvement Measure	5
C28	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	4
C29	Reviewing Appeals Decisions	Measures Capturing Access	4
C30	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	4

*Plan All-Cause Readmissions has a weight of 1 for the 2024 Star Ratings because it is considered a new measure.

Table G-2: Part D Measure Weights

Measure ID	Measure Name	Weighting Category	Part D Summary and MA-PD Overall
D01	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	4
D02	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	4
D03	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	4
D04	Drug Plan Quality Improvement	Improvement Measure	5
D05	Rating of Drug Plan	Patients' Experience and Complaints Measure	4
D06	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	4
D07	MPF Price Accuracy	Process Measure	1
D08*	Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3
D09*	Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3
D10*	Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3
D11	MTM Program Completion Rate for CMR	Process Measure	1
D12	Statin Use in Persons with Diabetes (SUPD)	Process Measure	1

*For contracts whose service area only covers Puerto Rico, the weight for each adherence measure is set to zero (0) when calculating the summary and overall rating.

Attachment H: Calculation of Weighted Star Rating and Variance Estimates

The weighted summary (or overall) Star Rating for contract *j* is estimated as:

$$\bar{x}_j = \frac{\sum_{i=1}^{n_j} w_{ij} x_{ij}}{\sum_{i=1}^{n_j} w_{ij}}$$

where n_j is the number of performance measures for which contract *j* is eligible; w_{ij} is the weight assigned to performance measure *i* for contract *j*; and x_{ij} is the measure star for performance measure *i* for contract *j*. The variance of the Star Ratings for each contract $j, s_j^2,$, must also be computed in order to estimate the reward factor (r-Factor):

$$s_j^2 = \frac{n_j}{(n_j - 1)(\sum_{i=1}^{n_j} w_{ij})} \left[\sum_{i=1}^{n_j} w_{ij} \left(x_{ij} - \bar{x}_j \right)^2 \right]$$

Thus, the $\bar{x}_j$'s are the new summary (or overall) Star Ratings for the contracts. The variance estimate, s_j^2 , simply replaces the non-weighted variance estimate that was previously used for the r-Factor calculation. For all contracts *j*, $w_{ij} = w_i$ (i.e., the performance measure weights are the same for all contracts when estimating a given Star Rating (Part C or Part D summary or MA-PD overall ratings).

Attachment I: Calculating the Improvement Measure and the Measures Used

Calculating the Improvement Measure

Contracts must have data for at least half of the attainment measures used to calculate the Part C or Part D improvement measure to be eligible to receive a rating in that improvement measure.

The improvement change score was determined for each measure for which a contract was eligible by calculating the difference in measure scores between Star Rating years 2023 and 2024.

For measures where a higher score is better:

Improvement Change Score = Score in 2024 - Score in 2023

For measures where a lower score is better:

Improvement Change Score = Score in 2023 - Score in 2024

An eligible measure was defined as a measure for which a contract was scored in both the 2023 and 2024 Star Ratings, and there were no significant measure specification changes or a regional contract reconfiguration for which only contract data is available from the original contract in one or both years.

For each measure, significant improvement or decline between Star Ratings years 2023 and 2024 was determined by a two-sided t-test at the 0.05 significance level:

$$\text{If } \frac{\text{Improvement Change Score}}{\text{Standard Error of Improvement Change Score}} > 1.96, \text{ then YES = significant improvement}$$

$$\text{If } \frac{\text{Improvement Change Score}}{\text{Standard Error of Improvement Change Score}} < -1.96, \text{ then YES = significant decline}$$

Hold Harmless Provision for Individual Measures: If a contract demonstrated statistically significant decline (at the 0.05 significance level) on an attainment measure for which they received five stars during both the current contract year and the prior contract year, then this measure will be counted as showing no significant change. Measures that are held harmless as described here will be considered eligible for the improvement measure. Net improvement is calculated for each class of measures (e.g., outcome, access, and process) by subtracting the number of significantly declined measures from the number of significantly improved measures.

Net Improvement = Number of significantly improved measures - Number of significantly declined measures

The improvement measure score is calculated for Parts C and D separately by taking a weighted sum of net improvement divided by the weighted sum of the number of eligible measures.

Measures are generally weighted as follows:

Outcome or intermediate outcome measure: Weight of 3

Access or patient experience/complaints measure: Weight of 4

Process measure: Weight of 1

Specific weights for each measure, which may deviate from the general scheme above are described in Attachment G. When the weight of an individual measure changes over the two years of data used, the newer weight value is used in the improvement calculation.

$$\text{Improvement Measure Score} = \frac{\text{Net_Imp_Process} + 3 * \text{Net_Imp_Outcome} + 4 * \text{Net_Imp_PtExp}}{\text{Elig_Process} + 3 * \text{Elig_Outcome} + 4 * \text{Elig_PtExp}}$$

Net_Imp_Process = Net improvement for process measures
Net_Imp_Outcome = Net improvement for outcome and intermediate outcome measures
Net_Imp_PtExp = Net improvement for patient experience/complaints and access measures
Elig_Process = Number of eligible process measures
Elig_Outcome = Number of eligible outcome and intermediate outcome measures
Elig_PtExp = Number of eligible patient experience/complaints and access measures

The improvement measure score is converted into a Star Rating using the clustering method. Conceptually, the clustering algorithm identifies the "gaps" in the data and creates cut points that result in the creation of five categories (one for each Star Rating) such that scores of contracts in the same score category (Star Rating) are as similar as possible, and scores of contracts in different categories are as different as possible. Improvement scores of 0 (equivalent to no net change on the attainment measures included in the improvement measure calculation) will be centered at 3 stars when assigning the improvement measure Star Rating. Then, the remaining contracts are split into two groups and clustered: 1) improvement scores less than zero receive one or two stars on the improvement measure and 2) improvement scores greater than or equal to zero receive 3, 4, or 5 stars.

General Standard Error Formula

Because a contract's score on a given measure in one year is not independent of its score in the next year, the standard error for the improvement change score for each measure is calculated using the standard approach for estimating the variance of the difference between two variables that may not be independent. In particular, the standard error of the improvement change score is calculated using the formula:

$$\sqrt{se(Y_{i2})^2 + se(Y_{i1})^2 - 2 * Cov(Y_{i2}, Y_{i1})}$$

Using measure C01 as an example, the change score standard error is:

$se(Y_{i2})$ Represents the 2024 standard error for contract i on measure C01

$se(Y_{i1})$ Represents the 2023 standard error for contract i on measure C01

Y_{i2} Represents the 2024 rate for contract i on measure C01

Y_{i1} Represents the 2023 rate for contract i on measure C01

cov Represents the covariance between Y_{i2} and Y_{i1} computed using the correlation across all contracts observed at both time points (2024 and 2023). In other words:

$$cov(Y_{i2}, Y_{i1}) = se(Y_{i2}) * se(Y_{i1}) * Corr(Y_{i2}, Y_{i1})$$

where the correlation $Corr(Y_{i2}, Y_{i1})$ is assumed to be the same for all contracts and is computed using data for all contracts. This assumption is needed because only one score is observed for each contract in each year; therefore, it is not possible to compute a contract specific correlation.

Improvement Change Score Standard Error Numerical Example

For measure C03, contract A:

$se(Y_{i2})$ = 2.805

$se(Y_{i1})$ = 3.000

$Corr(Y_{i2}, Y_{i1})$ = 0.901

Improvement change score standard error for measure C03 for contract
A = sqrt $(2.805^2 + 3.000^2 - 2 * 0.901 * 2.805 * 3.000) = 1.305$

Standard Error Formulas (SEF) for Specific Measures

The following formulas are used for calculating the contract-specific standard errors for specific measures in the 2024 Star Ratings. These standard errors are used in calculating the improvement change score standard error.

1. SEF for Measures: C01, C02, C04, C05, C08 – C14, C16, C26, C28 – C30, D01, D03, D08 – D12

$$SE_y = \sqrt{\frac{Score_y * (100 - Score_y)}{Denominator_y}}$$

for y = 2023, 2024
$Denominator_y$ is as defined in the Measure Details section for each measure.

2. SEF for Measures: C06, C07

These measures are rolled up from the plan level to the contract level following the formula outlined in Attachment E: NCQA HEDIS Measures. The standard error at the contract level is calculated as shown below. The specifications are written for two PBP submissions, which we distinguish as 1 and 2, but the methodology easily extends to any number of submissions.

The plan level standard error is calculated as:

$$SE_{yj} = \sqrt{\frac{Score_{yj} * (100 - Score_{yj})}{Denominator_{yj}}}$$

for y = 2023, 2024 and j = Plan 1, Plan 2

The contract level standard error is then calculated as:

Let W_{y1} = The weight assigned to the first PBP results (estimated, auditable) for year y, where y = 2023, 2024. This result is estimated by the formula $W_{y1} = N_{y1} / (N_{y1} + N_{y2})$

Let W_{y2} = The weight assigned to the second PBP results (estimated, auditable) for year y, where y = 2023, 2024. This result is estimated by the formula $W_{y2} = N_{y2} / (N_{y1} + N_{y2})$

$$SE_{yi} = \sqrt{(W_{y1})^2 * (SE_{y1})^2 + (W_{y2})^2 * (SE_{y2})^2}$$

for y = Contract Year 2023, Contract Year 2024 and i = Contract i

3. SEF for Measures: C03, C19 – C24, and D05, D06

The CAHPS measure standard errors for 2023 and 2024 were provided to CMS by the CAHPS contractor following the formulas documented in the CAHPS Macro Manual. The actual values used for each contract are included on the Measure Detail CAHPS page in the HPMS preview area.

4. SEF for Measures C25, D02

$$SE_y = \sqrt{\frac{\text{Total Number of Complaints}_y}{(\text{Average Contract Enrollment}_y)^2}} * \frac{1000*30}{\text{NumDays}}$$

NumDays: 2023 = 365, 2024 = 365

5. SEF for Measure D07

The standard error of the MPF Composite Price Accuracy Score for each contract is calculated by using binomial approximations for each of the component scores (Price Accuracy Score and Claim Percentage Score, as described in Attachment M). Since the MPF Composite Price Accuracy Score is equal to (0.5 x Price Accuracy Score) + (0.5 x Claim Percentage Score), the composite measure's variance (and standard error) is a function of the variance of the Price Accuracy Score, the variance of the Claim Percentage Score, and the covariance between them. We assume that the product of the total PDE cost and the Price Accuracy Score (on a 0-1 scale) follows a binomial distribution, and likewise that the product of the number of PDE claims and the Claim Percentage Score (on a 0-1 scale) also follows a binomial distribution. With these assumptions in place, the standard error of the MPF Composite Accuracy Score is calculated as follows:

1. The contract's component scores, on their original 0-100 scale, have variances calculable using formulas based on the binomial variance assumptions described above, separately for each year y = 2023, 2024.

    a. For the Price Accuracy Score, the variance in year y is represented by

$$Var\left(Price\ Acc.Score_y\right) = \frac{\left(Price\ Acc.Score_y \times \left(100 - Price\ Acc.Score_y\right)\right)}{Total\ PDE\ Cost_y}$$

    b. For the Claim Percentage Score, the variance in year y is represented by

$$Var\left(Claims\ Pct.Score_y\right) = \frac{\left(Claims\ Pct.Score_y \times \left(100 - Claims\ Pct.Score_y\right)\right)}{Number\ of\ PDE\ Claims_y}$$

2. The contract-specific covariance between the component scores, shown as $Cov\left(Price\ Acc.\ Score_y, Claim\ Pct.\ Score_y\right)$ in step 3 below, is calculated as the product of:
    a. the contract-specific standard errors of the two component scores, which are the square roots of the two variance estimates shown above in step 1, and
    b. the correlation between the two component scores estimated based on all contracts.
3. The standard error of the MPF Composite Price Accuracy Score is calculated from the components calculated in steps 1 and 2 as shown below:

$$SE_y = \sqrt{\frac{Var\left(Price\ Acc.\ Score_y\right)}{4} + \frac{Var\left(Claim\ Pct.\ Score_y\right)}{4} + \frac{Cov\left(Price\ Acc.\ Score_y, Claim\ Pct.\ Score_y\right)}{2}}$$

for y = 2023, 2024

Star Ratings Measures Used in the Improvement Measures

Table I-1: Part C Measures Used in the Improvement Measure

Measure ID	Measure Name	Measure Usage	Correlation
C01	Breast Cancer Screening	Included	0.927677
C02	Colorectal Cancer Screening	Included	0.743188
C03	Annual Flu Vaccine	Included	0.903184
C04	Monitoring Physical Activity	Included	0.839155
C05	Special Needs Plan (SNP) Care Management	Included	0.899492
C06	Care for Older Adults – Medication Review	Included	0.507510
C07	Care for Older Adults – Pain Assessment	Included	0.399811
C08	Osteoporosis Management in Women who had a Fracture	Included	0.861517
C09	Diabetes Care – Eye Exam	Included	0.853405
C10	Diabetes Care – Blood Sugar Controlled	Included	0.827107
C11	Controlling Blood Pressure	Included	0.786307
C12	Reducing the Risk of Falling	Included	0.830616
C13	Improving Bladder Control	Included	0.474745
C14	Medication Reconciliation Post-Discharge	Included	0.844615
C15	Plan All-Cause Readmissions	Not Included	-
C16	Statin Therapy for Patients with Cardiovascular Disease	Included	0.681168
C17	Transitions of Care	Not Included	-
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Not Included	-
C19	Getting Needed Care	Included	0.788466
C20	Getting Appointments and Care Quickly	Included	0.798595
C21	Customer Service	Included	0.736046
C22	Rating of Health Care Quality	Included	0.699480
C23	Rating of Health Plan	Included	0.877493
C24	Care Coordination	Included	0.692131
C25	Complaints about the Health Plan	Included	0.871058
C26	Members Choosing to Leave the Plan	Included	0.902728
C27	Health Plan Quality Improvement	Not Included	-
C28	Plan Makes Timely Decisions about Appeals	Included	0.715785
C29	Reviewing Appeals Decisions	Included	0.641752
C30	Call Center – Foreign Language Interpreter and TTY Availability	Included	0.207234

Table I-2: Part D Measures Used in the Improvement Measure

Measure ID	Measure Name	Measure Usage	Correlation
D01	Call Center – Foreign Language Interpreter and TTY Availability	Included	0.179690
D02	Complaints about the Drug Plan	Included	0.873781
D03	Members Choosing to Leave the Plan	Included	0.899679
D04	Drug Plan Quality Improvement	Not Included	-
D05	Rating of Drug Plan	Included	0.863090
D06	Getting Needed Prescription Drugs	Included	0.716532
D07	MPF Price Accuracy	Included	0.660011
D08	Medication Adherence for Diabetes Medications	Included	0.715904
D09	Medication Adherence for Hypertension (RAS antagonists)	Included	0.781854
D10	Medication Adherence for Cholesterol (Statins)	Included	0.829572
D11	MTM Program Completion Rate for CMR	Included	0.847085
D12	Statin Use in Persons with Diabetes (SUPD)	Included	0.833716

Attachment J: Star Ratings Measure History

The tables below cross-reference the measures code in each of the yearly Star Ratings releases. Measure codes that begin with DM are display measures which are posted on CMS.gov on this page: http://go.cms.gov/partcanddstarratings.

Table J-1: Part C Measure History

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
C	Access to Primary Care Doctor Visits	HEDIS		DMC08	DMC09	DMC09	DMC09	DMC09	DMC10	DMC10	DMC11	DMC10	DMC12	DMC12	C11	C13
C	Adult BMI Assessment	HEDIS				C07	C07	C07	C07	C07	C07	C08	C10	C10	C12	DMC05
C	Annual Flu Vaccine	CAHPS	C03	C03	C03	C03	C03	C03	C03	C03	C03	C04	C06	C06	C06	C07
C	Antidepressant Medication Management (6 months)	HEDIS	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03
C	Appropriate Monitoring of Patients Taking Long-term Medications	HEDIS							DMC04	DMC04	DMC05	DMC05	DMC05	DMC05	DMC05	C08
C	Asthma Medication Ratio	HEDIS							DMC18	DMC27						
C	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	C30	C28	C28	DME08	C31	C31	C32	C33
C	Breast Cancer Screening	HEDIS	C01	C01	C01	C01	C01	C01	C01	C01	C01	DMC22	C01	C01	C01	C01
C	Call Answer Timeliness	HEDIS									DMC02	DMC02	DMC02	DMC02	DMC02	DMC02
C	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMC06	DMC06	DMC07	DMC07	DMC07	DMC07	DMC08	DMC08	DMC09		DMC09	DMC09	DMC09	C34
C	Call Center - Calls Disconnected When Customer Calls Health Plan	Call Center Monitoring	DMC09	DMC09	DMC10	DMC10	DMC10	DMC10	DMC11	DMC11	DMC12		DMC15	DMC15		
C	Call Center – CSR Understandability	Call Center Monitoring														
C	Call Center – Foreign Language Interpreter and TTY Availability	Call Center Monitoring	C30	C28	C28	C32	C33	C34	C34	C32	C32		C36	C36	C36	C36
C	Call Center – Information Accuracy	Call Center Monitoring											DMC10	DMC10	DMC10	C35
C	Cardiac Rehabilitation – Achievement	HEDIS	DMC25	DMC29												
C	Cardiac Rehabilitation – Engagement 1	HEDIS	DMC26	DMC30												
C	Cardiac Rehabilitation – Engagement 2	HEDIS	DMC27	DMC31												
C	Cardiac Rehabilitation – Initiation	HEDIS	DMC28	DCM32												
C	Cardiovascular Care – Cholesterol Screening	HEDIS										C02	C03	C03	C03	C03
C	Care Coordination	CAHPS	C24	C22	C22	C26	C27	C28	C27	C25	C25	C28	C29	C29		

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
C	Care for Older Adults – Functional Status Assessment	HEDIS	DMC21	DMC25	DCM25	C10	C10	C10	C10	C10	C10	C11	C12	C12	C14	
C	Care for Older Adults – Medication Review	HEDIS	C06	C06	C06	C09	C09	C09	C09	C09	C09	C10	C11	C11	C13	
C	Care for Older Adults – Pain Assessment	HEDIS	C07	C07	C07	C11	C11	C11	C11	C11	C11	C12	C13	C13	C15	
C	Colorectal Cancer Screening	HEDIS	C02	C02	C02	C02	C02	C02	C02	C02	C02	C01	C02	C02	C02	C02
C	Colorectal Cancer Screening – Age 45-75	HEDIS	DMC29													
C	Complaints about the Health Plan	CTM	C25/D02	C23/D02	C23/D02	C27/ D04	C28/ D04	C29 / D04	C28 / D04	C26 / D04	C26 / D04	C29 / D03	C30 / D04	C30 / D06	C31 / D06	C30
C	Computer use by provider helpful	CAHPS								DMC20	DMC21	DMC20				
C	Computer use made talking to provider easier	CAHPS								DMC21	DMC22	DMC21				
C	Computer used during office visits	CAHPS								DMC19	DMC20	DMC19				
C	Continuous Beta Blocker Treatment	HEDIS	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC04	DMC04	DMC04	DMC04	DMC04	DMC04
C	Controlling Blood Pressure	HEDIS	C11	C12	DMC16	DMC16	DMC17	C16	C16	C16	C16	C18	C19	C19	C21	C19
C	Customer Service	CAHPS	C21	C19	C19	C23	C24	C25	C24	C22	C22	C25	C26	C26	C28	C27
C	Diabetes Care – Blood Sugar Controlled	HEDIS	C10	C11	C11	C15	C15	C15	C15	C15	C15	C16	C17	C17	C19	C17
C	Diabetes Care – Cholesterol Controlled	HEDIS										C17	C18	C18	C20	C18
C	Diabetes Care – Cholesterol Screening	HEDIS										C03	C04	C04	C04	C04
C	Diabetes Care – Eye Exam	HEDIS	C09	C09	C09	C13	C13	C13	C13	C13	C13	C14	C15	C15	C17	C15
C	Diabetes Care – Kidney Disease Monitoring	HEDIS		C10	C10	C14	C14	C14	C14	C14	C14	C15	C16	C16	C18	C16
C	Doctors who Communicate Well	CAHPS	DMC05	DMC05	DMC06	DMC06	DMC06	DMC06	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC08	C25
C	Engagement of Substance Use Disorder (SUD) Treatment	HEDIS	DMC13	DMC13	DMC14	DMC14	DMC14	DMC14	DMC15	DMC15	DMC16	DMC15	DMC19			
C	Enrollment Timeliness	MARx							DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	DMD03
C	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS	C18	DMC15	DMC17	DMC17	DMC18									

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
C	Follow-up visit after Hospital Stay for Mental Illness (within 30 days of Discharge)	HEDIS	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01
C	Getting Appointments and Care Quickly	CAHPS	C20	C18	C18	C22	C23	C24	C23	C21	C21	C24	C25	C25	C27	C26
C	Getting Needed Care	CAHPS	C19	C17	C17	C21	C22	C23	C22	C20	C20	C23	C24	C24	C26	C24
C	Glaucoma Testing	HEDIS											C05	C05	C05	C05
C	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11		
C	Health Plan Quality Improvement	Star Ratings	C27	C25	C25	C29	C30	C31	C31	C29	C29	C31	C33	C33		
C	Hospitalizations for Potentially Preventable Complications	HEDIS	DMC15	DMC14	DMC15	DMC15	DMC15	DMC15	DMC16	DMC24						
C	Improving Bladder Control	HEDIS-HOS	C13	C14	C14	C18	C18	C19	C19	DMC22	DMC23	C20	C21	C21	C23	C22
C	Improving or Maintaining Mental Health	HOS	DMC23	DMC27	DMC27	C05	C05	C05	C05	C05	C05	C06	C08	C08	C09	C10
C	Improving or Maintaining Physical Health	HOS	DMC24	DMC28	DMC28	C04	C04	C04	C04	C04	C04	C05	C07	C07	C08	C09
C	Initiation and Engagement of Substance Use Disorder (SUD) Treatment Average	HEDIS	DMC14													
C	Initiation of Substance Use Disorder (SUD) Treatment	HEDIS	DMC12	DMC12	DMC13	DMC13	DMC13	DMC13	DMC14	DMC14	DMC15	DMC14	DMC18			
C	Kidney Health Evaluation for Patients with Diabetes	HEDIS	DMC22	DMC26												
C	Medication Management for People With Asthma	HEDIS								DMC26						
C	Medication Reconciliation Post-Discharge	HEDIS	C14	C15	C15	C19	C19	C20	C20	DMC23						
C	Members Choosing to Leave the Plan	MBDSS	C26/D03	C24/D03	C24/D03	C28/ D05	C29/ D05	C30 / D05	C29 / D05	C27 / D05	C27 / D05	C30 / D04	C32 / D06	C32 / D08	C33 / D08	DME01
C	Monitoring Physical Activity	HEDIS-HOS	C04	C04	C04	C06	C06	C06	C06	C06	C06	C07	C09	C09	C10	C12
C	Osteoporosis Management in Women who had a Fracture	HEDIS	C08	C08	C08	C12	C12	C12	C12	C12	C12	C13	C14	C14	C16	C14
C	Osteoporosis Testing	HEDIS-HOS			DMC04	DMC04	DMC04	DMC04	DMC05	DMC05	DMC06	DMC06	DMC06	DMC06	DMC06	C11
C	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	HEDIS	DMC11	DMC11	DMC12	DMC12	DMC12	DMC12	DMC13	DMC13	DMC14	DMC13	DMC17			

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
C	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	HEDIS	DMC10	DMC10	DMC11	DMC11	DMC11	DMC11	DMC12	DMC12	DMC13	DMC12	DMC16			
C	Physical Functioning Activities of Daily Living	HOS	DMC20	DMC24												
C	Plan All-Cause Readmissions	HEDIS	C15	DMC21	DMC23	DMC23	C20	C21	C21	C19	C19	C22	C23	C23	C25	
C	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE) / Maximus	C28	C26	C26	C30	C31	C32	C32	C30	C30	C32	C34	C34	C34	C31
C	Pneumonia Vaccine	CAHPS	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC09	DMC09	DMC10	DMC09	DMC11	DMC11	C07	C08
C	Rating of Health Care Quality	CAHPS	C22	C20	C20	C24	C25	C26	C25	C23	C23	C26	C27	C27	C29	C28
C	Rating of Health Plan	CAHPS	C23	C21	C21	C25	C26	C27	C26	C24	C24	C27	C28	C28	C30	C29
C	Reducing the Risk of Falling	HEDIS-HOS	C12	C13	C13	C17	C17	C18	C18	C18	C18	C21	C22	C22	C24	C23
C	Reminders for appointments	CAHPS								DMC16	DMC17	DMC16				
C	Reminders for immunizations	CAHPS								DMC17	DMC18	DMC17				
C	Reminders for screening tests	CAHPS								DMC18	DMC19	DMC18				
C	Reviewing Appeals Decisions	Independent Review Entity (IRE) / Maximus	C29	C27	C27	C31	C32	C33	C33	C31	C31	C33	C35	C35	C35	C32
C	Rheumatoid Arthritis Management	HEDIS			C12	C16	C16	C17	C17	C17	C17	C19	C20	C20	C22	C20
C	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	C05	C05	C05	C08	C08	C08	C08	C08	C08	C09	DMC14	DMC14		
C	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	C16	C16	C16	C20	C21	C22	DMC17	DMC25						
C	Testing to Confirm Chronic Obstructive Pulmonary Disease	HEDIS	DMC04	DMC04	DMC05	DMC05	DMC05	DMC05	DMC06	DMC06	DMC07	DMC07	DMC07	DMC07	DMC07	C21
C	Transitions of Care – Average	HEDIS	C17	DMC20	DMC22	DMC22	DMC23									
C	Transitions of Care – Medication Reconciliation Post-Discharge	HEDIS	DMC16	DMC16	DMC18	DMC18	DMC19									
C	Transitions of Care – Notification of Inpatient Admission	HEDIS	DMC17	DMC17	DMC19	DMC19	DMC20									
C	Transitions of Care – Patient Engagement After Inpatient Discharge	HEDIS	DMC18	DMC18	DMC20	DMC20	DMC21									

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
C	Transitions of Care – Receipt of Discharge Information	HEDIS	DMC19	DMC19	DMC21	DMC21	DMC22									

Table J-2: Part D Measure History

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	Notes
D	4Rx Timeliness	Acumen / OIS (4Rx)													DMD03	D07	
D	Adherence – Proportion of Days Covered	Prescription Drug Event (PDE) Data														DMD07	
D	Antipsychotic Use in Persons with Dementia	Prescription Drug Event (PDE) Data	DMD08	DMD08	DMD08	DMD12	DMD14	DMD16	DMD18								
D	Appeals Auto–Forward	Independent Review Entity (IRE) / Maximus				D02	D02	D02	D02	D02	D02	D01	D02	D03	D03	D05	
D	Appeals Upheld	Independent Review Entity (IRE) / Maximus				D03	D03	D03	D03	D03	D03	D02	D03	D04	D04	D06	
D	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	D06	D06	D06	DME08	D05	D07	D07	D10	
D	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMD02	DMD02	DMD02	DMD04	DMD04	DMD04	DMD04	DMD04	DMD04		DMD04	DMD04	DMD05	D01	
D	Call Center – Calls Disconnected – Pharmacist	Call Center Monitoring															
D	Call Center – Calls Disconnected When Customer Calls Drug Plan	Call Center Monitoring	DMD01	DMD01	DMD01	DMD03	DMD03	DMD03	DMD03	DMD03	DMD03		DMD03	DMD03	DMD04	DMD04	
D	Call Center – CSR Understandability	Call Center Monitoring															
D	Call Center – Foreign Language Interpreter and TTY Availability	Call Center Monitoring	D01	D01	D01	D01	D01	D01	D01	D01	D01		D01	D02	D02	D04	
D	Call Center – Information Accuracy	Call Center Monitoring											DMD05	DMD05	DMD06	D03	
D	Call Center – Pharmacy Hold Time	Call Center Monitoring	DMD04	DMD04	DMD04	DMD08	DMD09	DMD09	DMD09	DMD11	DMD11		DMD15	D01	D01	D02	
D	Complaint Resolution	Complaints Tracking Module (CTM)															
D	Complaints – Enrollment	Complaints Tracking Module (CTM)														D08	
D	Complaints – Other	Complaints Tracking Module (CTM)														D09	

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	Notes
D	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	C25/ D02	C23/ D02	C23/ D02	C27 / D04	C28 / D04	C29 / D04	C28 / D04	C26 / D04	C26 / D04	C29 / D03	C30 / D04	C30 / D06	C31 / D06		
D	Diabetes Medication Dosing	Prescription Drug Event (PDE) Data					DMD06	DMD06	DMD06	DMD06	DMD06	DMD04	DMD07	DMD07	DMD08	DMD06	
D	Diabetes Treatment	Prescription Drug Event (PDE) Data										D10	D12	D15	D14	D17	
D	Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website	Acumen / OIT (LIS Match Rates)				DMD06	DMD07	DMD07	DMD07	DMD07	DMD07	DMD05	DMD08	DMD08	DMD09	D14	
D	Drug Plan Quality Improvement	Star Ratings	D04	D04	D04	D06	D06	D06	D07	D07	D07	D05	D07	D09			
D	Drug-Drug Interactions	Prescription Drug Event (PDE) Data				DMD05	DMD05	DMD05	DMD05	DMD05	DMD05	DMD03	DMD06	DMD06	DMD07	DMD05	
D	Enrollment Timeliness	MARx							DME01	DME01	DME01	DME01	DME01	C37 / D06	D05	DMD03	
D	Formulary Administration Analysis	Part D Sponsor						DMD15	DMD17								
D	Getting Information From Drug Plan	CAHPS								DMD10	DMD10	DMD09	DMD14	D10	D09	D11	
D	Getting Needed Prescription Drugs	CAHPS	D06	D06	D06	D08	D08	D08	D09	D09	D09	D07	D09	D12	D11	D13	
D	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11			
D	High Risk Medication	Prescription Drug Event (PDE) Data					DMD14	DMD14	DMD16	D11	D11	D09	D11	D14	D13	D16	
D	Initial Opioid Prescribing	Prescription Drug Event (PDE) Data	DMD15	DMD15													
D	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Data	D10	D10	D10	D12	D12	D12	D13	D14	D14	D13	D15	D18	D17		
D	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) Data	D08	D08	D08	D10	D10	D10	D11	D12	D12	D11	D13	D16	D15		
D	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) Data	D09	D09	D09	D11	D11	D11	D12	D13	D13	D12	D14	D17	D16		
D	Members Choosing to Leave the Plan	MBDSS	C26/ D03	C24/ D03	C24/ D03	C28 / D05	C29 / D05	C30 / D05	C29 / D05	C27 / D05	C27 / D05	C30 / D04	C32 / D06	C32 / D08	C33 / D08	DME01	
D	MPF – Composite	PDE Data, MPF Pricing Files													D12	D15	B

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	Notes
D	MPF – Stability	PDE Data, MPF Pricing Files	DMD03	DMD03	DMD03	DMD07	DMD08	DMD08	DMD08	DMD08	DMD08	DMD06	DMD10	DMD10			A
D	MPF – Updates	PDE Data, MPF Pricing Files											DMD09	DMD09	DMD10	DMD08	
D	MPF Price Accuracy	PDE Data, MPF Pricing Files	D07	D07	D07	D09	D09	D09	D10	D10	D10	D08	D10	D13			A
D	MTM Program Completion Rate for CMR	Prescription Drug Event (PDE) Data	D11	D11	D11	D13	D13	D13	D14	D15	D15	DMD07	DMD12	DMD12			
D	Persistence to Basal Insulin (PST-INS)	Prescription Drug Event (PDE) Data	DMD16														
D	Plan Submitted Higher Prices for Display on MPF	PDE Data, MPF Pricing Files	DMD05	DMD05	DMD05	DMD09	DMD10	DMD10	DMD10	DMD12	DMD12	DMD10	DMD16				
D	Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	Prescription Drug Event (PDE) Data	DMD13	DMD13	DMD13	DMD20											
D	Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)	Prescription Drug Event (PDE) Data	DMD14	DMD14	DMD14	DMD21											
D	Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes	Fu Associates								DMD09	DMD09	DMD08	DMD13	DMD13			
D	Rating of Drug Plan	CAHPS	D05	D05	D05	D07	D07	D07	D08	D08	D08	D06	D08	D11	D10	D12	
D	Reminders to fill prescriptions	CAHPS	DMD06	DMD06	DMD06	DMD10	DMD11	DMD12	DMD13	DMD15	DMD15	DMD13					
D	Reminders to take medications	CAHPS	DMD07	DMD07	DMD07	DMD11	DMD12	DMD13	DMD14	DMD16	DMD16	DMD14					
D	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Data	D12	D12	D12	D14	D14	D14	DMD15	DMD17							
D	Timely Effectuation of Appeals	Independent Review Entity (IRE) / Maximus				DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	
D	Timely Receipt of Case Files for Appeals	Independent Review Entity (IRE) / Maximus				DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	
D	Transition monitoring	Transition Monitoring Program Analysis						DMD11									D
D	Transition monitoring – failure rate for all other drugs	Transition Monitoring Program Analysis							DMD12	DMD14	DMD14	DMD12					C

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	Notes
D	Transition monitoring – failure rate for drugs within classes of clinical concern	Transition Monitoring Program Analysis							DMD11	DMD13	DMD13	DMD11					C
D	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP)	Prescription Drug Event (PDE) Data				DMD15											
D	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Prescription Drug Event (PDE) Data	DMD11	DMD11	DMD11	DMD18											
D	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	Prescription Drug Event (PDE) Data	DMD12	DMD12	DMD12	DMD19											

Notes:

A: Part of composite measure MPF - Composite in 2011 – 2012

B: Composite measure - combined MPF - Accuracy and MPF Stability

C: Part of composite measure Transition Monitoring - Composite starting in 2019

D: Composite Measure – "Transition monitoring - failure rate for drugs within classes of clinical concern" and "Transition monitoring - failure rate for all other drugs"

Table J-3: Common Part C & Part D Measure History

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
E	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	C30 / D06	C28 / D06	C28 / D06	DME08	C31 / D05	C31 / D07	C32 / D07	C33 / D10
E	Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-Only, PDP)	Disenrollment Reasons Survey	DME04	DME04	DME04	DME04	DME04	DME04	DME05	DME05	DME05	DME05				
E	Disenrollment Reasons - Problems Getting Information and Help from the Plan (MA-PD, PDP)	Disenrollment Reasons Survey	DME06	DME06	DME06	DME06	DME06	DME06	DME07	DME07	DME07	DME07				
E	Disenrollment Reasons - Problems Getting the Plan to Provide and Pay for Needed Care (MA-PD, MA-Only)	Disenrollment Reasons Survey	DME02	DME02	DME02	DME02	DME02	DME02	DME03	DME03	DME03	DME03				
E	Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-Only)	Disenrollment Reasons Survey	DME03	DME03	DME03	DME03	DME03	DME03	DME04	DME04	DME04	DME04				
E	Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)	Disenrollment Reasons Survey	DME05	DME05	DME05	DME05	DME05	DME05	DME06	DME06	DME06	DME06				
E	Enrollment Timeliness	MARx							DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	DMD03
E	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11		

Attachment K: Individual Measure Star Assignment Process

This attachment provides detailed information about the clustering and the relative distribution and significance testing (CAHPS) methodologies used to assign stars to individual measures.

Clustering Methodology Introduction

To separate a distribution of scores into distinct groups or categories, a set of values must be identified to separate one group from another group. The set of values that break the distribution of the scores into non-overlapping groups is the set of cut points.

For each individual measure, CMS determines the measure cut points using the information provided from the hierarchical clustering algorithm in SAS, described in "Clustering Methodology Detail" below. Conceptually, the clustering algorithm identifies the natural gaps that exist within the distribution of the scores and creates groups (clusters) that are then used to identify the cut points that result in the creation of a pre-specified number of categories.

For Star Ratings, the algorithm is run with the goal of determining the four cut points (labeled in the Figure J-1 below as A, B, C, and D) that are used to create the five non-overlapping groups that correspond to each of the Star Ratings (labeled in the diagram below as G1, G2, G3, G4, and G5). For Part D measures, CMS determines MA-PD and PDP cut points separately. Data identified to be biased, erroneous, or excluded by disaster rules are removed from the algorithm. The scores are grouped such that scores within the same Star Rating category are as similar as possible, and scores in different categories are as different as possible.

Figure K-1: Diagram showing gaps in data where cut points are assigned.

As mentioned, the cut points are used to create five non-overlapping groups. The value of the lower bound for each group is included in the category, while the value of the upper bound is not included in the category. CMS does not require the same number of observations (contracts) within each group. The groups are identified such that within a group the measure scores must be similar to each other and between groups, the measure scores in one group are not similar to measure scores in another group. The groups are then used for the conversion of the measure scores to one of five Star Ratings categories. For most measures, a higher score is better, and thus, the group with the highest range of measure scores is converted to a rating of five stars. An example of a measure for which higher is better is *Medication Adherence for Diabetes Medications*. For some measures a lower score is better, and thus, the group with the lowest range of measure scores is converted to a rating of five stars. An example of a measure for which a lower score is better is *Members Choosing to Leave the Plan*.

Example 1 – Clustering Methodology for a Higher is Better measure

Consider the information provided for the cut points for *Medication Adherence for Diabetes Medications* in Table K-1 below. As stated previously, for Part D measures CMS calculates MA-PD and PDP cut points separately (e.g., different cut points are calculated for MA-PD and PDPs). If the MA-PD cut points identified using the clustering algorithm are 80%, 85%, 87%, and 91%; for PDPs, the cut points are 84%, 86%, 88%, and 90%. (The set of values corresponds to the cut points in figure J-2 below as A, B, C, and D and the categories for each of the five Star Ratings are indicated above each group.) Since a measure score can only assume a value between 0% and 100% (including 0% and 100%), the one-star and five-star categories contain only a single value in the table below as the upper or lower bound.

Table K-1: Medication Adherence for Diabetes Medications cut points example: cut points are for illustrative purposes

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 80%	80% to less than 85%	85% to less than 87%	87% to less than 91%	greater than or equal to 91%
PDP	less than 84%	84% to less than 86%	86% to less than 88%	88% to less than 90%	greater than or equal to 90%

Figure K-2: Diagram showing star assignment based cut points.

Since higher is better for *Medication Adherence for Diabetes Medications*, a rating of one star is assigned to all MA-PD measure scores below 80% in this example. For each of the other Star Rating categories, the value of the lower bound is included in the rating category, while the upper bound value is not included. Focusing solely on the cut points for MA-PDs, a rating of two stars is assigned to each measure score that is at least 80% (the first cut point) to less than 85% (the second cut point) in this example. Since measure scores are reported as percentages with no decimal places, any measure score of 80% to 84% would be assigned two stars, while a measure score of 85% would be assigned a rating of three stars. Measure scores that are at least 85% to less than 87% would be assigned a rating of three stars. For a conversion to four stars, a measure score of at least 87% to less than 91% would be needed. A rating of five stars would be assigned to any measure score of 91% or more. PDPs have different cut points, but the same overall rules apply for converting the measure score to a Star Rating.

Example 2 – Clustering Methodology for a Lower is Better measure

Consider the information provided for the cut points for *Members Choosing to Leave the Plan* in Table K-2 below. As stated previously, for Part D measures CMS calculates MA-PD and PDP cut points separately. In the example, the MA-PD cut points for *Members Choosing to Leave the Plan* determined using the clustering algorithm are 44%, 29%, 16%, and 9%; for PDPs, the cut points are 20%, 13%, 19%, and 6%. (These correspond to the cut points in figure J-3 as A, B, C, and D).

Since lower is better for this measure, the five-star category will have the lowest measure score range, while the one-star category will have scores that are highest in value. For each of the other Star Rating categories, the value of the lower bound is not included in the rating category, while the upper bound value is included. (The inclusivity and exclusivity of the upper and lower bounds is opposite for a measure score where lower is better as compared to higher is better.) For MA-PDs, a rating of five stars would be assigned to measure scores of 9% or less. Measure scores that are greater than 9% up to a maximum value of 16% (including a measure score of 16%) would be assigned a rating of four stars. A rating of three stars would be assigned to measure scores greater than 16% up to a maximum value of 29%. A rating of two stars would be assigned to a measure score that is greater than 29% up to and including 44%. A rating of one star would be assigned to any measure score greater than 44%. PDPs have different cut points, but the same overall rules apply for converting the measure score to a Star Rating.

Table K-2: Members Choosing to Leave the Plan cut points example: cut points are for illustrative purposes

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	greater than 44%	greater than 29% to 44%	greater than 16% to 29%	greater than 9% to 16%	less than or equal to 9%
PDP	greater than 20%	greater than13% to 20%	greater than 9% to 13%	greater than 6% to 9%	less than or equal to 6%

Figure J-3: Diagram showing star assignment based on cut points.

Clustering Methodology Detail

This section details the steps of the clustering method performed in SAS to allow the conversion of the measure scores to measure-level stars.

Tukey outlier deletion is used to determine the cut points for all non-CAHPS measures. Tukey outlier deletion involves removing Tukey outer fence outlier contract scores, those defined as measure-specific scores outside the bounds of 3.0 times the measure-specific interquartile range subtracted from the 1st quartile or added to the 3rd quartile. Outliers are removed prior to applying mean resampling to the hierarchical clustering algorithm. The 1st and 3rd quartiles can be obtained by using the MEANS procedure in SAS. The Tukey outer fence outlier cutoffs can then be calculated as:

- Lower outlier cutoff: first quartile – 3.0*(third quartile – first quartile).
- Upper outlier cutoff: third quartile + 3.0*(third quartile – first quartile).

Measures with data displays of percentages with no decimal places ranging from 0 to 100 will have the lower and upper outlier cutoffs capped at those values, respectively. Any other measures with range restrictions, such as have a lower bound of zero, will have the respective outlier cutoff capped at the restricted value.

Mean resampling is used to determine the cut points for all non-CAHPS measures. With mean resampling, measure-specific scores for the current year's Star Ratings are separated into 10 equal-sized groups, using a random assignment process to assign each contract's measure score to a group. The random assignment of contracts into 10 groups can be produced using the SURVEYSELECT procedure in SAS as follows:
proc surveyselect data=inclusterdat groups=10 seed=8675309 out=inclusterdat_random;
run;

In the above code, the input dataset, *inclusterdat*, is the list of contracts without missing, flagged, excluded by disaster rules or voluntary contract scores for a particular measure. The *group=10* option identifies that 10 random groupings of the data should be created. The *seed=8675309* option specifies the seed value that controls the starting point of the random sequence of numbers and allows for future replication of the randomization process. The output dataset, *inclusterdat_random*, is identical to the input dataset with the addition of a new column, named *groupid*, that has the group assignments (from 1 through 10) for each contract.
The hierarchal clustering algorithm (steps 1 through 4 below) is then applied 10 times, each time leaving out one of the 10 groups. For each measure and leave-one-out contract set, the clustering method does the following:

- Produces the individual measure distance matrix.
- Groups the measure scores into an initial set of clusters.
- Selects the set of clusters.

1. **Produce the individual measure distance matrix.**

   For each pair of contracts j and k (j>=k) among the n contracts with measure score data, compute the Euclidian distance of their measure scores (e.g., the absolute value of the difference between the two

measure scores). Enter this distance in row j and column k of a distance matrix with n rows and n columns. This matrix can be produced using the DISTANCE procedure in SAS as follows:

```
proc distance data= inclusterdat  leave1out out=distancedat method=Euclid;
        var interval(measure_score);
        id contract_id;
    run;
```

In the above code, the input data set, *inclusterdat_leave1out*, is the list of contracts (excluding the group left out) without missing, flagged, excluded by disaster rules or voluntary contract scores for a particular measure. Each record has a unique contract identifier, *contract_id*. The option *method=Euclid* specifies that distances between contract measure scores should be based on Euclidean distance. The input data contain a variable called *measure_score* that is formatted to the display criteria outlined in the Technical Notes. In the *var* call, the parentheses around *measure_score* indicate that *measure_score* is considered to be an interval or numeric variable. The distances computed by this code are stored to an output data set called *distancedat.*

2. Create a tree of cluster assignments.

The distance matrix calculated in Step 1 is the input to the clustering procedure. The stored distance algorithm is implemented to compute cluster assignments. The following process is implemented by using the CLUSTER procedure in SAS:

- The input measure score distances are squared.
- The clusters are initialized by assigning each contract to its own cluster.
- In order to determine which pair of clusters to merge, Ward's minimum variance method is used to separate the variance of the measure scores into within-cluster and between-cluster sum of squares components.
- From the existing clusters, two clusters are selected for merging to minimize the within-cluster sum of squares over all possible sets of clusters that might result from a merge.
- Steps 3 and 4 are repeated to reduce the number of clusters by one until a single cluster containing all contracts results.

The result is a data set that contains a tree-like structure of cluster assignments, from which any number of clusters between 1 and the number of contract measure scores could be computed. The SAS code for implementing these steps is:

```
proc cluster data=distancedat method=ward outtree=treedat noprint;
        id contract_id;
    run;
```

The *distancedat* data set containing the Euclidian distances was created in Step 1. The option *method=ward* indicates that Ward's minimum variance method should be used to group clusters. The output data set is denoted with the *outtree* option and is called *treedat.*

3. Select the final set of clusters from the tree of cluster assignments.

The process outlined in Step 2 will produce a tree of cluster assignments, from which the final number of clusters is selected using the TREE procedure in SAS as follows:

```
proc tree data=treedat ncl=NSTARS horizontal out=outclusterdat noprint;
        id contract_id;
```

run;

The input data set, treedat, is created in Step 2 above. The syntax, ncl=NSTARS, denotes the desired final number of clusters (or star levels). For most measures, NSTARS= 5. In cases where multiple clusters have the same score value range those clusters are combined, leading to fewer than 5 clusters. Since the improvement measures have a constraint that contracts with improvement scores of zero or greater are to be assigned at least 3 stars for improvement, the clustering is conducted separately for contract measure scores that are greater than or equal to zero versus those that are less than zero. Specifically, Steps 1-3 are first applied to contracts with improvement scores that meet or exceed zero, in which case NSTARS equals three. The resulting improvement measure stars can take on values of 3, 4, or 5. For those contracts with improvement scores less than zero, Steps 1-3 are applied with NSTARS=2 and these contracts will either receive 1 or 2 stars.

4. Final Thresholds

The cluster assignments produced by the above approach have cluster labels that are unordered. The final step after applying the above steps to all contract measure scores is to order the cluster labels so that the 5-star category reflects the cluster with the best performance and the 1-star category reflects the cluster with the worst performance. With the exception of the improvement measures which are assigned lower thresholds of zero for the 3-star category, the measure thresholds are defined by examining the range of measure scores within each of the final clusters. The lower limit of each cluster becomes the cut point for the star categories.

Determining Stars from Scores and Thresholds

The mean-resampling approach results in 10 sets of measure-specific cut points, one for each of the 10 implementations of the hierarchical clustering algorithm. For higher-is-better measures, the minimum score observed in each star category defines the effective cut points for the star categories. For lower-is-better measures, the maximum score observed in each star category defines the effective cut points for the star categories. These cut points are calculated after the application of Tukey outlier deletion. The final set of estimated thresholds are then calculated as the mean cut point for each threshold per measure from the 10 different cut point values. Tables K-3 and K-4 show the mean resampling final estimated thresholds for the 2024 Star Ratings. Tables K-5 and K-6 show the upper and lower Tukey outlier cutoffs.

Table K-3: 2024 Star Ratings Part C non-CAHPS Measure Mean Resampling Estimated Thresholds

Measure ID	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C01	less than 52%	52% to less than 63%	63% to less than 71%	71% to less than 79%	greater than or equal to 79%
C02	less than 48%	48% to less than 60%	60% to less than 71%	71% to less than 80%	greater than or equal to 80%
C04	less than 42%	42% to less than 48%	48% to less than 53%	53% to less than 58%	greater than or equal to 58%
C05	less than 42%	42% to less than 55%	55% to less than 74%	74% to less than 85%	greater than or equal to 85%
C06	less than 72%	72% to less than 84%	84% to less than 93%	93% to less than 98%	greater than or equal to 98%
C07	less than 74%	74% to less than 83%	83% to less than 91%	91% to less than 96%	greater than or equal to 96%
C08	less than 28%	28% to less than 39%	39% to less than 50%	50% to less than 60%	greater than or equal to 60%
C09	less than 53%	53% to less than 65%	65% to less than 73%	73% to less than 81%	greater than or equal to 81%
C10	less than 57%	57% to less than 72%	72% to less than 80%	80% to less than 87%	greater than or equal to 87%
C11	less than 58%	58% to less than 68%	68% to less than 74%	74% to less than 82%	greater than or equal to 82%
C12	less than 47%	47% to less than 53%	53% to less than 60%	60% to less than 70%	greater than or equal to 70%
C13	less than 38%	38% to less than 42%	42% to less than 47%	47% to less than 51%	greater than or equal to 51%
C14	less than 31%	31% to less than 51%	51% to less than 68%	68% to less than 82%	greater than or equal to 82%
C15	greater than 13%	greater than 11% to 13%	greater than 10% to 11%	greater than 8% to 10%	less than or equal to 8%
C16	less than 79%	79% to less than 84%	84% to less than 86%	86% to less than 90%	greater than or equal to 90%
C17	less than 40%	40 % to less than 52 %	52% to less than 64%	64% to less than 78%	greater than or equal to 78%
C18	less than 44%	44% to less than 53%	53% to less than 60%	60% to less than 68%	greater than or equal to 68%
C25	greater than 1	greater than 0.6 to 1	greater than 0.33 to 0.6	greater than 0.14 to 0.33	less than or equal to 0.14
C26	greater than 41%	greater than 29% to 41%	greater than 18% to 29%	greater than 10% to 18%	less than or equal to 10%
C27	less than -0.246067	-0.246067 to less than 0	0 to less than 0.173502	0.173502 to less than 0.393451	greater than or equal to 0.393451
C28	less than 77%	77% to less than 86%	86% to less than 94%	94% to less than 98%	greater than or equal to 98%
C29	less than 87%	87% to less than 92%	92% to less than 96%	96% to less than 100%	greater than or equal to 100%
C30	less than 87%	87% to less than 90%	90% to less than 94%	94% to less than 97%	greater than or equal to 97%

Notes: These are not the final thresholds for the 2024 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table K-4: 2024 Star Ratings Part D non-CAHPS Measure Mean Resampling Estimated Thresholds

Measure ID	Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
D01	MA-PD	less than 85%	85% to less than 91%	91% to less than 96%	96% to less than 99%	greater than or equal to 99%
D01	PDP	less than 95%	95% to less than 97%	97% to less than 98%	98% to less than100%	greater than or equal to 100%
D02	MA-PD	greater than 1	less than 0.6 to 1	greater than 0.33 to 0.6	greater than 0.14 to 0.33	less than or equal to 0.14
D02	PDP	greater than 0.12	greater than 0.08 to 0.12	greater than 0.05 to 0.08	greater than 0.02 to 0.05	less than or equal to 0.02
D03	MA-PD	greater than 41%	greater than 29% to 41%	greater than 18% to 29%	greater than 10% to 18%	less than or equal to 10%
D03	PDP	greater than 25%	greater than 17% to 25%	greater than 11% to 17%	greater than 7% to 11%	less than or equal to 7%
D04	MA-PD	less than -0.253472	-0.253472 to less than 0	0 to less than 0.193739	0.193739 to less than 0.458889	greater than or equal to 0.458889
D04	PDP	less than -0.123026	-0.123026 to less than 0	0 to less than 0.214538	0.214538 to less than 0.401223	greater than or equal to 0.401223
D07	MA-PD	less than 94	94 to less than 96	96 to less than 98	98 to less than 99	greater than or equal to 99
D07	PDP	less than 96	96 to less than 97	97 to less than 98	98 to less than 99	greater than or equal to 99
D08	MA-PD	less than 80%	80% to less than 84%	84% to less than 88%	88% to less than 90%	greater than or equal to 90%
D08	PDP	less than 84%	84% to less than 87%	87% to less than 89%	89% to less than 93%	greater than or equal to 93%
D09	MA-PD	less than 82%	82% to less than 86%	86% to less than 89%	89% to less than 91%	greater than or equal to 91%
D09	PDP	less than 87%	87% to less than 89%	89% to less than 91%	91% to less than 94%	greater than or equal to 94%
D10	MA-PD	less than 82%	82% to less than 86%	86% to less than 88%	88% to less than 91%	greater than or equal to 91%
D10	PDP	less than 84%	84% to less than 87%	87% to less than 89%	89% to less than 93%	greater than or equal to 93%
D11	MA-PD	less than 67%	67% to less than 77%	77% to less than 85%	85% to less than 92%	greater than or equal to 92%
D11	PDP	less than 34%	34% to less than 52%	52% to less than 63%	63% to less than 77%	greater than or equal to 77%
D12	MA-PD	less than 81%	81% to less than 86%	86% to less than 88%	88% to less than 92%	greater than or equal to 92%
D12	PDP	less than 81%	81% to less than 83%	83% to less than 85%	85% to less than 87%	greater than or equal to 87%

Notes: These are not the final thresholds for the 2024 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table K-5: 2024 Star Ratings Part C non-CAHPS Measure Tukey Outlier Cutoffs

Measure ID	Lower Cutoff	Upper Cutoff
C01	30	100
C02	26	100
C04	25	74
C05	0	100
C06	59	100
C07	57	100
C08	0	100
C09	27	100
C10	38	100
C11	38	100
C12	27	83
C13	24	66
C14	0	100
C15	4	18
C16	71	99
C17	0	100
C18	28	84
C25	0	1.41
C26	0	87.5
C27 (improve)	0	0.807245
C27 (decline)	-0.726192	0
C28	70	100
C29	78	100
C30	82	100

Notes: If the calculated lower or upper outer fence exceeds the minimum or maximum range of the measure, then the minimum or maximum measure score is shown in the table. This means that no outliers were identified at that end of the measure score range. For C27 (decline) group, the upper cut off is technically the lowest value below zero since zero is included in the C27 (improved) group.

Table K-6: 2024 Star Ratings Part D non-CAHPS Measure Tukey Outlier Cutoffs

Measure ID	Type	Lower Cutoff	Upper Cutoff
D01	MA-PD	74	100
D02	MA-PD	0	1.41
D03	MA-PD	0	87.5
D04 (improve)	MA-PD	0	1.297044
D04 (decline)	MA-PD	-0.7343755	0
D07	MA-PD	91	105
D08	MA-PD	72	100
D09	MA-PD	74	100
D10	MA-PD	73	100
D11	MA-PD	53	100
D12	MA-PD	68	100
D01	PDP	86	100
D02	PDP	0	0.26
D03	PDP	0	62
D04 (improve)	PDP	0	0.96875
D04 (decline)	PDP	-1.130433	0
D07	PDP	94	101
D08	PDP	76	97
D09	PDP	80	97.5
D10	PDP	77	98
D11	PDP	0	100
D12	PDP	72	93

Note: If the calculated lower or upper outer fence exceeds the minimum or maximum range of the measure, then the minimum or maximum measure score is shown in the table. This means that no outliers were identified at that end of the measure score range. For D04 (decline) group, the upper cut off is technically the lowest value below zero since zero is included in the D04 (improved) group.

Guardrails are then applied to all non-CAHPS measures, with a few exceptions. Guardrails are not applied to the Part C and Part D improvement measures. Additionally, guardrails are not applied to new measures that have been in the Part C and D Star Rating program for 3 years or less. Cut points for these new measures and improvement measures are based on the hierarchal clustering methodology with mean resampling. When applying guardrails, the difference between the current year and prior year's cut point is calculated for each of the 1 to 5 star levels. A cap value is then calculated and compared to the observed threshold difference.

- For measures having a 0 to 100 scale, an absolute percentage cap of 5 percentage point is applied.
  - If the absolute difference between the current and prior year's cut point is less than or equal to 5 percentage points, the current year's cut point is used as the final cut point value.
  - If the absolute difference between the current and prior year's cut point is greater than 5 percentage points, a 5 percentage point cap is applied. That is, 5 percentage points are added to or subtracted

from the prior year's cut point value (depending on the direction of movement for the cut point value in the current year) to obtain the final cut point value for the current year.

- For measures not having a 0 to 100 scale, a restricted range cap of 5 percent of the prior year's score range is applied. Specifically, the restricted range cap is equal to the prior year's (maximum score value – minimum score value) * 0.05.
  - If the absolute difference between the current and prior year's is less than or equal to the calculated restricted range cap value, the current year's cut point is used as the final cut point value.
  - If the absolute difference between the current and prior year's is greater than the calculated restricted range cap value, then the restricted range cap is applied. That is, the calculated restricted range cap value is added to or subtracted from the prior year's cut point value (depending on the direction of the movement of the cut point value in the current year) to obtain the final cut point value for the current year.

When we proposed and finalized Tukey outlier deletion in the 2021 final rule (CMS–4190–F), we described that in the first year of adding Tukey outlier deletion, the prior year's thresholds would be rerun, including mean resampling and Tukey outer fence deletion so that the guardrails would be applied such that there is consistency between the years. For the purposes of calculating the guardrails for the 2024 Star Ratings, the 2023 Star Ratings cut points were rerun including mean resampling, Tukey outlier deletion and no guardrails. These rerun 2023 Star Ratings cut points serve as the basis for applying the guardrails for the 2024 Star Ratings and are shown in Tables K-7 and K-8.

Table K-7: 2023 Star Ratings Part C Mean Resampling and Tukey Outlier Deletion Non-CAHPS Measure Thresholds

Measure ID	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C01	less than 50%	50% to less than 63%	63% to less than 71%	71% to less than 76%	greater than or equal to 76%
C02	less than 55%	55% to less than 66%	66% to less than 74%	74% to less than 81%	greater than or equal to 81%
C04	less than 44%	44% to less than 49%	49% to less than 53%	53% to less than 57%	greater than or equal to 57%
C05	less than 46%	46% to less than 62%	62% to less than 75%	75% to less than 85%	greater than or equal to 85%
C06	less than 73%	73% to less than 82%	82% to less than 91%	91% to less than 96%	greater than or equal to 96%
C07	less than 73%	73% to less than 83%	83% to less than 89%	89% to less than 95%	greater than or equal to 95%
C08	less than 34%	34% to less than 47%	47% to less than 60%	60% to less than 76%	greater than or equal to 76%
C09	less than 47%	47% to less than 61%	61% to less than 71%	71% to less than 79%	greater than or equal to 79%
C10	less than 63%	63% to less than 72%	72% to less than 80%	80% to less than 86%	greater than or equal to 86%
C12	less than 46%	46 % to less than 53 %	53% to less than 60%	60% to less than 69%	greater than or equal to 69%
C13	less than 39%	39 % to less than 43 %	43% to less than 48%	48% to less than 53%	greater than or equal to 53%
C14	less than 43%	43 % to less than 57 %	57% to less than 69%	69% to less than 82%	greater than or equal to 82%
C16	less than 79%	79% to less than 84%	84% to less than 86%	86% to less than 89%	greater than or equal to 89%
C25	greater than 0.68	greater than 0.68 to 0.43	greater than 0.43 to 0.25	greater than 0.25 to 0.12	less than or equal to 0.12
C26	less than 37%	37% to less than 24%	24% to less than 15%	15% to less than 7%	greater than or equal to 7%
C28	less than 89%	89% to less than 93%	93% to less than 97%	97% to less than 100%	equal to 100%
C29	less than 84%	84% to less than 90%	90% to less than 95%	95% to less than 98%	greater than or equal to 98%
C30	less than 67%	67% to less than 78%	78% to less than 87%	87% to less than 94%	greater than or equal to 94%

Table K-8: 2023 Star Ratings Part D Mean Resampling and Tukey Outlier Deletion Non-CAHPS Measure Thresholds

Measure ID	Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
D01	MA-PD	less than 68%	68% to less than 81%	81% to less than 91%	91% to less than 97%	greater than or equal to 97%
D01	PDP	less than 86%	86% to less than 92%	92% to less than 97%	97% to less than 100%	equal to 100%
D02	MA-PD	greater than 0.68	greater than 0.68 to 0.43	greater than 0.43 to 0.25	greater than 0.25 to 0.12	less than or equal to 0.12
D02	PDP	greater than 0.15	greater than 0.15 to 0.1	greater than 0.1 to 0.07	greater than 0.07 to 0.03	less than or equal to 0.03
D03	MA-PD	greater than 37%	greater than 37% to 24%	greater than 24% to 15%	greater than 15 % to 7%	less than or equal to 7%
D03	PDP	greater than 18%	greater than 18% to13%	greater than 13% to 9%	greater than 9% to 5%	less than or equal to 5%
D08	MA-PD	less than 81%	81% to less than 85%	85% to less than 88%	88% to less than 92%	greater than or equal to 92%
D08	PDP	less than 84%	84% to less than 86%	86% to less than 88%	88% to less than 90%	greater than or equal to 90%
D09	MA-PD	less than 83%	83% to less than 86%	86% to less than 89%	89% to less than 91%	greater than or equal to 91%
D09	PDP	less than 86%	86% to less than 88%	88% to less than 89%	89% to less than 91%	greater than or equal to 91%
D10	MA-PD	less than 81%	81% to less than 85%	85% to less than 88%	88% to less than 92%	greater than or equal to 92%
D10	PDP	less than 86%	86% to less than 87%	87% to less than 88%	88% to less than 90%	greater than or equal to 90%
D11	MA-PD	less than 68%	68% to less than 78%	78% to less than 84 %	84% to less than 91%	greater than or equal to 91%
D11	PDP	less than 34%	34% to less than 49%	49% to less than 62%	62% to less than 78%	greater than or equal to 78%
D12	MA-PD	less than 80%	80% to less than 84%	84% to less than 86%	86% to less than 90%	greater than or equal to 90%
D12	PDP	less than 80%	80% to less than 82%	82% to less than 84%	84% to less than 86%	greater than or equal to 86%

Relative Distribution and Significance Testing (CAHPS) Methodology

The CAHPS measures are case-mix adjusted to take into account differences in the characteristics of enrollees across contracts that may potentially impact survey responses. See Attachment A for the case-mix adjusters. The percentile cut points for base groups are defined by current-year distribution of case-mix adjusted contract means. Percentile cut points are rounded to the nearest integer on the 0-100 reporting scale, and each base group includes those contracts whose rounded mean score is at or above the lower limit and below the upper limit. The number of stars assigned is determined by the position of the contract mean score relative to percentile cutoffs from the distribution of contract weighted mean scores from all contracts (which determines the base group); statistical significance of the difference of the contract mean from the national mean along with the direction of the difference; the statistical reliability of the estimate (based on the ratio of sampling variation for each contract mean to between-contract variation); and the standard error of the mean score. All statistical tests, including comparisons involving standard errors, are computed using unrounded scores.

CAHPS reliability calculation details are provided under the section header, "MA & PDP CAHPS Between-Contract Variances for Reported Measures" at https://www.ma-pdpcahps.org/en/scoring-and-star-ratings. Tables K-9 and K-10 contain the rules applied to determine the final CAHPS measure star value.

Table K-9: CAHPS Star Assignment Rules

Star	Criteria for Assigning Star Ratings
1	A contract is assigned one star if both criteria (a) and (b) are met plus at least one of criteria (c) and (d): (a) its average CAHPS measure score is lower than the 15th percentile; AND (b) its average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score; (c) the reliability is not low; OR (d) its average CAHPS measure score is more than one standard error (SE) below the 15th percentile.
2	A contract is assigned two stars if it does not meet the one-star criteria and meets at least one of these three criteria: (a) its average CAHPS measure score is lower than the 30th percentile and the measure does not have low reliability; OR (b) its average CAHPS measure score is lower than the 15th percentile and the measure has low reliability; OR (c) its average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score and below the 60th percentile.
3	A contract is assigned three stars if it meets at least one of these three criteria: (a) its average CAHPS measure score is at or above the 30th percentile and lower than the 60th percentile, AND it is not statistically significantly different from the national average CAHPS measure score; OR (b) its average CAHPS measure score is at or above the 15th percentile and lower than the 30th percentile, AND the reliability is low, AND the score is not statistically significantly lower than the national average CAHPS measure score; OR (c) its average CAHPS measure score is at or above the 60th percentile and lower than the 80th percentile, AND the reliability is low, AND the score is not statistically significantly higher than the national average CAHPS measure score.
4	A contract is assigned four stars if it does not meet the five-star criteria and meets at least one of these three criteria: (a) its average CAHPS measure score is at or above the 60th percentile and the measure does not have low reliability; OR (b) its average CAHPS measure score is at or above the 80th percentile and the measure has low reliability; OR (c) its average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score and above the 30th percentile.
5	A contract is assigned five stars if both criteria (a) and (b) are met plus at least one of criteria (c) and (d): (a) its average CAHPS measure score is at or above the 80th percentile; AND (b) its average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score; (c) the reliability is not low; OR (d) its average CAHPS measure score is more than one standard error (SE) above the 80th percentile.

Table K-10: CAHPS Star Assignment Alternate Representation

Mean Score	Base Group	Signif. below avg., low reliability	Signif. below avg., not low reliability	Not signif. diff. from avg., low reliability	Not signif. diff. from avg., not low reliability	Signif. above avg., low reliability	Signif. above avg., not low reliability
less than 15th percentile by greater than 1 SE	1	1	1	2	2	2	2
less than 15th percentile by less than or equal to 1 SE		2	1	2	2	2	2
greater than or equal to 15th to less than 30th percentile	2	2	2	3	2	3	2
greater than or equal to 30th to less than 60th percentile	3	2	2	3	3	4	4
greater than or equal to 60th to less than 80th percentile	4	3	4	3	4	4	4
greater than or equal to 80th percentile by less than or equal to 1 SE	5	4	4	4	4	4	5
greater than or equal to 80th percentile by greater than 1 SE		4	4	4	4	5	5

Notes: If reliability is very low (<0.60), the contract does not receive a Star Rating. Low reliability scores are defined as those with at least 11 respondents and reliability ≥0.60 but <0.75 and also in the lowest 12% of contracts ordered by reliability. The SE is considered when the measure score is below the 15th percentile (in base group 1), significantly below average, and has low reliability: in this case, 1 star is assigned if and only if the measure score is at least 1 SE below the unrounded base group 1/2 cut point. Similarly, the SE is considered when the measure score is at or above the 80th percentile (in base group 5), significantly above average, and has low reliability: in this case, 5 stars are assigned if and only if the measure score is at least 1 SE above the unrounded base group 4/5 cut point.
For example, a contract in base group 4 that was not significantly different from average and had low reliability would receive 3 final stars.

As noted above, low reliability scores for CAHPS measures are defined as those with at least 11 respondents and reliability ≥0.60 but <0.75 and also in the lowest 12% of contracts ordered by reliability. Table K-11 contains the 12% reliability cutoffs.

Table K-11: CAHPS Measure 12% Reliability Cutoffs

Measure	12% Reliability Cutoff
Annual Flu Vaccine	0.853836*
Getting Needed Care	0.751402*
Getting Appointments and Care Quickly	0.722606
Customer Service	0.634544
Rating of Health Care Quality	0.655488
Rating of Health Plan	0.828638*
Care Coordination	0.636025
Rating of Drug Plan (MA-PD)	0.787018*
Getting Needed Prescription Drugs (MA-PD)	0.628637
Rating of Drug Plan (PDP)	0.950305*
Getting Needed Prescription Drugs (PDP)	0.833025*

*Note: Reliabilities must be ≥0.60 but <0.75 and also in the lowest 12% of contracts ordered by reliability to be designated as low reliability, thus these cutoffs did not affect low reliability designation.

Attachment L: Medication Adherence Measure Calculations

Part D sponsors currently have access to monthly Patient Safety Reports via the Patient Safety Analysis Web Portal to compare their performance to overall rates and monitor their progress in improving the Part D patient safety measures over time. Sponsors may use the website to view and download the reports for performance monitoring.

Report User Guides are available on the Patient Safety Analysis Web Portal under Help Documents and provide detailed information about the measure calculations and reports. The following information is an excerpt from the Adherence Measures Report Guide (Appendices A and B) and illustrates the days covered calculation and the modification for inpatient stays and skilled nursing facility stays.

Proportion of Days Covered Calculation

In calculating the Proportion of Days Covered (PDC), we first count the number of days the patient was "covered" by at least one drug in the target drug class. The number of days is based on the prescription fill date and days' supply. PDC is calculated by dividing the number of covered days by the number of days in the measurement period. Both of these numbers may be adjusted for IP/SNF stays, as described in the 'Calculating the PDC Adjustment for IP Stays and SNF Stays' section that follows.

Example 1: Non-Overlapping Fills of Two Different Drugs

In this example, a beneficiary fills Benazepril and Captopril, two drugs in the RAS antagonist hypertension target drug class. The covered days do not overlap, meaning the beneficiary filled the Captopril prescription after the days' supply for the Benazepril medication ended.

Table L-1: No Adjustment

	January		February		March	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022
Benazepril	15	16	15	13		
Captopril					15	16

PDC Calculation
Covered Days: 90
Measurement Period: 90
PDC: 90/90 = 100%

Example 2: Overlapping Fills of the Same Generic Ingredient across Single and Combination Products

In this example, a beneficiary fills a drug with the same target generic ingredient prior to the end of the days' supply of the first fill. In rows one and two, there is an overlap between a single and combination drug product, both containing Lisinopril. For this scenario, the overlapping days are shifted because the combination drug product includes the targeted generic ingredient. An adjustment is made to the PDC to account for the overlap in days covered.

In rows two and three, there is an overlap between two combination drug products, both containing Hydrochlorothiazide. However, Hydrochlorothiazide is not a RAS antagonist or targeted generic ingredient, so this overlap is not shifted.

Table L-2: Before Overlap Adjustment

	January		February		March	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022
Lisinopril	15	16				
Lisinopril & HCTZ		16	15			
Benazepril & HCTZ			15	13		

PDC Calculation
Covered Days: 59
Measurement Period: 90
PDC: 59/90 = 66%

Table L-3: After Overlap Adjustment

	January		February		March	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022
Lisinopril	15	16				
Lisinopril & HCTZ			15	13	3	
Benazepril & HCTZ			15	13		

PDC Calculation
Covered Days: 62
Measurement Period: 90
PDC: 62/90 = 69%

Example 3: Overlapping Fills of the Same and Different Target Drugs
In this example, a beneficiary is refilling both Lisinopril and Captopril. When a single and combination product both containing Lisinopril overlap, there is an adjustment to the PDC. When Lisinopril overlaps with Captopril, we do not make any adjustment to the days covered.

Table L-4: Before Overlap Adjustment

	January		February		March		April	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022	4/1/2022	4/16/2022
Lisinopril	15	16						
Lisinopril & HCTZ		16	15					
Captopril					15	16		
Lisinopril						16	15	

PDC Calculation
Covered Days: 92
Measurement Period: 120
PDC: 92/120: 77%

Table L-5: After Overlap Adjustment

	January		February		March		April	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022	4/1/2022	4/16/2022
Lisinopril	15	16						
Lisinopril & HCTZ			15	13	3			
Captopril					15	16		
Lisinopril						16	15	

PDC Calculation
Covered Days: 105
Measurement Period: 120
PDC: 105/120: 88%

PDC Adjustment for Inpatient, and Skilled Nursing Facility Stays Examples

In response to Part D sponsor feedback, CMS modified the PDC calculation, starting with the 2013 Star Ratings (using 2011 PDE data) to adjust for beneficiary stays in inpatient (IP) facilities, and with the 2015 Star Ratings (using 2013 PDE data) to also adjust for hospice enrollments and beneficiary stays in skilled nursing facilities (SNF). These adjustments account for periods that the Part D sponsor would not be responsible for providing prescription fills for targeted medications or more accurately reflect drugs covered under the hospice benefit or waived through the beneficiary's hospice election; thus, their medication fills during an IP or SNF stay or during hospice enrollment would not be included in the PDE claims used to calculate the Patient Safety adherence measures.

The PDC modification for IP stays, hospice enrollments, and SNF stays reflects this situation. Please note that while this modification will enhance the adherence measure calculation, extensive testing indicates that most Part D contracts will experience a negligible impact on their adherence rates. On average, the 2011 adherence rates increased 0.4 to 0.6 percentage points due to the inpatient stay adjustment, and the adjustment may impact the rates positively or negatively.

The hospice and SNF adjustments were tested on 2013 PDE data and overall increased the rates by 0.13 to 0.15 percentage points and 0.29 to 0.35 percentage points, respectively. Hospice information from the Medicare Enrollment Database (EDB) and inpatient claims from the Common Working File (CWF) are available for both PDPs and MA-PDs. SNF claims from the CWF have been used to adjust the SNF PDC adjustments for PDPs. Starting in the 2019 measurement year, when available for MA-PDs in the CWF, adjust the SNF PDC adjustments. Additionally, starting in 2019 measurement year, when available for MA-PDs in the encounter data, adjust for SNF/IP stays for MA-PD beneficiaries. Additionally, starting in 2020 measurement year, when available for MA-PDs in the encounter data, adjust for SNF/IP stays for MA-PD beneficiaries.

Note: Hospice enrollment is no longer a PDC adjustment but rather an exclusion starting with the 2020 Star Ratings (2018 YOS).

Calculating the PDC Adjustment for IP Stays and SNF Stays

The PDC modification for IP stays and SNF stays is based on two assumptions: 1) a beneficiary receives their medications through the facility during the IP or SNF stay, and 2) if a beneficiary accumulates an extra supply of their Part D medication during an IP stay or SNF stay, that supply can be used once he/she returns home. The modification is applied using the steps below:

- Identify start and end dates of relevant types of stays for beneficiaries included in adherence measures. The discharge date is included in the PDC adjustment.
  - Use IP claims from the CWF to identify IP stays, and when available for MA-PDs.
  - Use SNF claims from the CWF for PDPs, and when available for MA-PD beneficiaries, for SNF PDC adjustments. (1) Use SNF claims from the CWF with either a positive or negative paid amount with Medicare utilization days to identify Medicare Part A covered SNF stays. (2) Use SNF claims from the CWF with a condition code 04 (Beneficiary enrolled in a MA-PD) not associated with a condition code 21 and/or a no payment reason code.
  - Use IP and SNF stay encounter data when available for MA-PD beneficiaries. Additionally, if IP and SNF stay claims for MA-PD enrolled beneficiaries are reported in the CWF, the CWF will remain as an additional data source.
- Remove days of relevant stays occurring during the measurement period from the numerator and denominator of the proportion of days covered calculation.
- Shift days' supply from Part D prescription fills that overlap with the stay or subsequent fills for the same drug class to uncovered days after the end of the relevant stay, if applicable. This assumes the beneficiary receives the relevant medication from a different source during the stay and accumulates the Part D prescription fills for later use.

If SNF and IP stays cover a beneficiary's entire enrollment episode that meets the inclusion criteria, the associated proportion of member-years is not included in the rate calculation. Consequently, if SNF and IP stays span all of the beneficiary's enrollment episode(s) within the measurement period, the beneficiary is excluded from the measurement year.

The following examples provide illustrations of the implementation of these assumptions when calculating PDC.

Example 1: Gap in Coverage after IP Stay

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills on different dates of service. This beneficiary had drug coverage on days 1-8 and 12-15 and an IP stay on days 5 and 6, as illustrated in Table L-6.

Table L-6: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1	X1				X2	X2	X2	X2
Inpatient Stay					+	+									

PDC Calculation:
Covered Days: 12
Measurement Period: 15
PDC: 12/15 = 80%

With the adjustment for the IP stay, days 5 and 6 are deleted from the measurement period. Additionally, the drug coverage during the IP stay is shifted to subsequent days of no supply (in this case, days 9 and 10), based on the assumption that if a beneficiary received his/her medication through the hospital on days 5 and 6, then he/she accumulated two extra days' supply during the IP stay. The two extra days' supply is used to cover the gaps in Part D drug coverage in days 9 and 10. This is illustrated in Table L-7.

Table L-7: After Adjustment

Day	1	2	3	4	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	+	+		X2	X2	X2	X2
Inpatient Stay													

PDC Calculation:
Covered Days: 12
Measurement Period: 13
PDC: 12/13 = 92%

Example 2: Gap in Coverage before IP Stay

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills on different dates of service. This beneficiary had drug coverage from days 1-7 and 12-15, and an IP stay on days 12 and 13, as illustrated in Table L-8.

Table L-8: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1					X2	X2	X2	X2
Inpatient Stay												+	+		

PDC Calculation:
Covered Days: 11
Measurement Period: 15
PDC: 11/15 = 73%

With the adjustment for the IP stay, days 12 and 13 are deleted from the measurement period. While there are two days' supply from the IP stay on days 12 and 13, there are no days without drug coverage after the IP stay. Thus, the extra days' supply are not shifted. This is illustrated in Table L-9.

Table L-9: After Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1					X2	X2
Inpatient Stay													

PDC Calculation:
Covered Days: 9
Measurement Period: 13
PDC: 9/13 = 69%

Example 3: Gap in Coverage Before and After IP Stay

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills on different dates of service. This beneficiary had drug coverage from days 1-3, 6-9, and 12-15, and an IP stay on days 6-9, as illustrated in Table L-10.

Table L-10: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1			X2	X2	X2	X2			X3	X3	X3	X3
Inpatient Stay						+	+	+	+						

PDC Calculation:
Covered Days: 11
Measurement Period: 15
PDC: 11/15 = 73%

With the adjustment for the IP stay, days 6-9 are deleted from the measurement period. Additionally, the drug coverage during the IP stay can be applied to any days without drug coverage after the IP stay, based on the assumption that the beneficiary received his/her medication through the hospital on days 6-9. In this case, only days 10 and 11 do not have drug coverage and are after the IP stay, so two days' supply are shifted to days 10 and 11. This is illustrated in Table L-11.

Table L-11: After Adjustment

Day	1	2	3	4	5	10	11	12	13	14	15
Drug Coverage	X1	X1	X1			+	+	X2	X2	X3	X3
Inpatient Stay											

PDC Calculation:
Covered Days: 9
Measurement Period: 11
PDC: 9/11 = 82%

Example 4: Gap in Coverage After IP Stay and Overlap with Subsequent Fill of the Same Drug Class

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills on different dates of service. This beneficiary had drug coverage from days 1-4, and 7-11 for the same drug class, and an IP stay on days 2-4, as illustrated in Table L-12.

Table L-12: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1			X2	X2	X2	X2	X2				
Inpatient Stay		+	+	+											

PDC Calculation:
Covered Days: 9
Measurement Period: 15
PDC: 9/15 = 60%

With the adjustment for the IP stay, days 2-4 are deleted from the measurement period. Additionally, the drug coverage during the IP stay can be applied to any days without drug coverage after the IP stay. In the case of overlapping days with a subsequent fill of the same drug class, the days supply of the subsequent fill are shifted. In this example, the days supply of 2 to 4 during the IP stay are shifted to days 5 to 7 after the IP stay. Because day 7 includes 1 days supply of a subsequent fill (X2) of the same drug class, days 7 to 11 that corresponds to the subsequent fill are shifted to days 8 to 12. This is illustrated in Table L-13.

Table L-13: After Adjustment

Day	1	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	+	+	+	X2	X2	X2	X2	X2			
Inpatient Stay												

PDC Calculation:
Covered Days: 9
Measurement Period: 12
PDC: 9/12 = 75%

Attachment M: Methodology for Price Accuracy Measure

CMS's drug pricing performance measure evaluates the accuracy of prices displayed on Medicare Plan Finder (MPF) for beneficiaries' comparison of plan options. The accuracy score is calculated by comparing the MPF price to the prescription drug event (PDE) price and determining the magnitude and frequency of differences found when the PDE price exceeds the MPF price. This document summarizes the methods currently used to construct each contract's MPF Composite Price Accuracy Score.

Contract Selection

The Part D Star Ratings rely in part on the submission of pricing data to MPF. Therefore, only contracts with at least one plan meeting all of the following criteria are included in the analysis:

Not a PACE plan
Not a demonstration plan
Not an employer plan
Part D plan
Plan not terminated during the contract year

Only contracts with at least 30 eligible claims throughout the year are included in the accuracy measure. This ensures that the sample size of PDEs is large enough to produce a reliable accuracy score.

MPF Composite Price Accuracy Score

To calculate the MPF Composite Price Accuracy Score, the point of sale cost (ingredient costs plus dispensing fee) reported on each PDE claim is compared to the cost resulting from using the unit price reported on Plan Finder.[1] This comparison includes only PDEs for which a MPF cost can be assigned. In particular, a PDE must meet seven conditions to be included in the analysis:

1. If the NPI in the Pharmacy Cost (PC) file represents a retail only pharmacy or retail and limited access drug only pharmacy, all corresponding PDEs will be eligible for the measure. However, if the NPI in the PC file represents a retail and other pharmacy type (such as Mail, Home Infusion or Long Term Care pharmacy), only the PDE where the pharmacy service type is identified as either Community/Retail or Managed Care Organization (MCO) will be eligible. NCPDP numbers are mapped to their corresponding NPI numbers.
2. The corresponding reference NDC must appear under the relevant price ID for the pharmacy in the pricing file.[2]
3. The reference NDC must be on the plan's formulary.
4. Because the retail unit cost reported on Plan Finder is intended to apply to a 1, 2, or 3-month supply of a drugs, only claims with a Days Supply of 28-34, 60-62, or 90-93 are included. If a plan's bid indicates a 1, 2, or 3 month retail days supply amount outside of the 28-34, 60-62, or 90-93 windows, then

[1] Medicare Plan Finder unit costs are reported by plan, drug, days of supply, and pharmacy. The plan, drug, days of supply and pharmacy from the PDE are used to assign the corresponding Medicare Plan Finder unit cost posted on medicare.gov on the date of the PDE.

[2] Medicare Plan Finder prices are reported at the reference NDC level. A reference NDC is a representative NDC of drugs with the same brand name, generic name, strength, and dosage form. To map NDCs on PDEs to a reference NDC, we use First Data Bank (FDB) and Medi-Span to create an expanded list of NDCs for each reference NDC, consisting of NDCs with the same brand name, generic name, strength, and dosage form as the reference NDC. This expanded NDC list allows us to map PDE NDCs to MPF reference NDCs.

additional days supply values may be included in the accuracy measure for the plan. For example, a plan that submits a 3 month retail supply of 100 days in their bid will have claims with a days supply of 90-100 included in their accuracy measure calculation.

5. PDEs for dates of service during which the plan was suppressed from Plan Finder or where the relevant pharmacy or drug was not reported in Plan Finder are not included since no Plan Finder cost can be assigned.[3]
6. PDEs for compound drugs or non-covered drugs are not included.
7. The PDE must occur in Quarter 1 through 3 of the year. Quarter 4 PDEs are not included because MPF prices are not updated during this last quarter.

The MPF Composite Price Accuracy Measure factors in both how much and how often PDE prices exceeded the prices reflected on the MPF. The contract's MPF Composite Price Accuracy score is the average of the Price Accuracy Score, which measures the difference between PDE total cost and MPF total cost,[4] and the Claim Percentage Score, which measures the share of claims where PDE prices are less than or equal to MPF prices.

Once MPF unit ingredient costs are assigned, the MPF ingredient cost is calculated by multiplying the unit costs reported on MPF by the quantity listed on the PDE. The PDE total cost (TC) is the sum of the PDE ingredient cost paid and the PDE dispensing fee. Likewise, the MPF TC is the sum of the MPF ingredient cost and the MPF dispensing fee that corresponds to the same pharmacy, plan, and days of supply as that observed in the PDE. Each claim is then given a score based on the difference between the PDE TC and the MPF TC. If the PDE TC is lower than or equal to the MPF TC, the claim receives a score equal to zero. In other words, contracts are not penalized when point of sale costs are lower than or equal to the advertised costs. However, if the PDE TC is higher than the MPF TC, then the claim receives a score equal to the difference between the PDE TC and the MPF TC.[5] [6] The contract level MPF Price Accuracy Index is the sum of the claim level scores and PDE TC across all PDEs that meet the inclusion criteria, divided by the PDE TC for those same claims. The MPF Claim Percentage Index is the percent of all PDEs that meet the inclusion criteria with a PDE TC higher than the MPF TC. Note that the best possible MPF Price Accuracy Index is 1, and the best possible MPF Claim Percentage Index is 0. This occurs when the MPF TC is never lower than the PDE TC. The formulas below illustrate the calculation of the contract level MPF Price Accuracy Index and MPF Claim Percentage Index:

$$\text{Price Accuracy Index} = \frac{\sum_i \max(TC_{iPDE} - TC_{iPF}, 0) + \sum_i TC_{iPDE}}{\sum_i TC_{iPDE}}$$

where

[3] Because CMS continues to display pharmacy and drug pricing data for sanctioned plans on MPF to their current enrollees, sanctioned plans are not excluded from this measure. If, however, CMS completely suppresses a sanctioned contract's data from MPF display, then they would be excluded from the measure.

[4] MPF total costs are rounded to the nearest cent. For example, if the MPF total cost is $10.237, then it is rounded to $10.24. MPF unit costs are not rounded.

[5] To account for potential rounding errors, this analysis requires that the PDE cost exceed the rounded MPF cost by at least a two cent ($0.02) in order to be counted towards the accuracy score. For example, if the PDE cost is $10.25 and the rounded MPF cost is $10.23, the 2-cent difference would be counted towards plan's accuracy score. However, if the rounded MPF cost is higher than $10.23, the difference would not count towards the plan's accuracy score.

[6] The MPF data includes floor pricing. For plan-pharmacy drugs with a floor price, if the MPF price is lower than the floor price, the PDE price is compared against the floor price.

TC_{iPDE} is the ingredient cost plus dispensing fee reported in PDE_i and TC_{iMPF} is the ingredient cost plus dispensing fee calculated from MPF data, based on the PDE_i reported NDC, days of supply, and pharmacy, then rounded to the nearest cent.

$$\text{Claim Percentage Index} = \frac{\sum_i \text{Claims}_{i\text{PDE}>\text{PF}}}{\sum_i \text{Claims}_{i\text{Total}}}$$

where

$\text{Claims}_{i\text{PDE}>\text{PF}}$ is the total number of claims where the PDE price is greater than the rounded MPF price

$\text{Claims}_{i\text{Total}}$ is the total number of claims

We use the following formulas to convert the Claim Percentage Index and Price Accuracy Index into the MPF.

Composite Price Accuracy score:

$$\text{Price Accuracy Score} = 100 - [(\text{Price Accuracy Index} - 1) \times 100]$$

$$\text{Claim Percentage Score} = (1 - \text{Claim Percentage Index}) \times 100$$

$$\text{MPF Composite Price Accuracy Score} = (0.5 \times \text{Price Accuracy Score}) + (0.5 \times \text{Claim Percentage Score})$$

The MPF Composite Price Accuracy Score is rounded to the nearest whole number.

Example of Accuracy Index Calculation

Table M-1 shows an example of the MPF Composite Price Accuracy Score calculation. This contract has 4 claims, for 4 different NDCs and 4 different pharmacies. This is an abbreviated example for illustrative purposes only; in the actual accuracy index, a contract must have 30 eligible claims to be evaluated.

From each of the 4 claims, the PDE ingredient cost, dispensing fee, and quantity dispensed are obtained. Additionally, the plan ID, days of supply, date of service, and pharmacy number are collected from each PDE to identify the MPF data that had been submitted by the contract and posted on Medicare.gov on the PDE dates of service. The NDC on the claim is first assigned the appropriate reference NDC, based on the brand name, generic name, strength, and dosage form. Using the reference NDC, the following MPF data are obtained: brand/generic dispensing fee (as assigned by the pharmacy cost file) and unit cost (as assigned by the Price File corresponding to that pharmacy and days of supply on the date of service). The PDE cost is the sum of the PDE ingredient cost and dispensing fee. The MPF cost is computed as the quantity dispensed from PDE multiplied by the MPF unit cost plus the MPF brand/generic dispensing fee (brand or generic status is assigned based on the NDC), and then rounded to the nearest cent. The last column shows the amount by which the PDE cost is higher than the rounded MPF cost. When PDE cost is less than or equal to the rounded MPF cost, this value is zero. The Price Accuracy Index is the sum of the last column plus the sum of PDE costs all divided by the sum of PDE costs. The Claim Percentage Index is the number of rows where the last column is greater than zero divided by the total number of rows.

Table M-1: Example of Price Accuracy Index Calculation

NDC	Pharmacy Number	PDE Data DOS	PDE Data Ingredient Cost	PDE Data Dispensing Fee	PDE Data Quantity Dispensed	PDE Days of Supply	MPF Data Biweekly Posting Period	MPF Data Unit Cost	MPF Data Dispensing Fee Brand	MPF Data Dispensing Fee Generic	Calculated Value Brand or Generic Status	Calculated Value Total Cost PDE	Calculated Value Total Cost MPF	Calculated Value Amount that PDE is higher than MPF
A	111	01/08/2022	3.82	2	60	60	01/06/22 - 01/19/22	0.014	2.25	2.75	B	5.82	3.09	2.73
B	222	01/24/2022	0.98	2	30	60	01/20/22 - 02/02/22	0.83	1.75	2.5	G	2.98	27.40	0
C	333	02/11/2022	10.48	1.5	24	28	02/03/22 - 02/16/22	0.483	2.5	2.5	B	11.98	14.09	0
D	444	02/21/2022	47	1.5	90	30	02/17/22 - 03/01/22	0.48	1.5	2.25	G	48.50	45.45	3.05
											Totals	69.28		5.78
											Price Accuracy Index			1.08343
											Claim Percentage Index			0.5
											MPF Composite Price Accuracy Score			71

PDE = Prescription Drug Event
MPF = Medicare Plan Finder

Attachment N: MTM CMR Completion Rate Measure Scoring Methodologies

Medicare Part D Reporting Requirements Measure (D11: MTM CMR Completion Rate Measure)

Step 1: Start with all contracts that enrolled beneficiaries in MTM at any point during contract year 2022. Beneficiaries with multiple records that contain varying information for the same contract are excluded from the measure calculation for that contract.

Step 2: Exclude contracts that did not enroll 31 or more beneficiaries in their MTM program who met the measure denominator criteria during contract year 2022.
Next, exclude contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2023), or that were not required to participate in data validation.
Additionally, exclude contracts that did not score at least 95% on data validation for their plan reporting of the MTM Program section and contracts that scored 95% or higher on data validation for the MTM Program section but that were not compliant with data validation standards/sub-standards for at least one of the following MTM data elements. We define a contract as being non-complaint if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation.

- MBI Number (Element B)
- Date of MTM program enrollment (Element H)
- Met the specified targeting criteria per CMS – Part D requirements (Element I)
- Date met the specified targeting criteria per CMS – Part D requirements (Element J)
- Date of MTM program opt-out, if applicable (Element K)
- Received annual CMR with written summary in CMS standardized format (Element O)
- Date(s) of CMR(s) (Element P)

Step 3: After removing contracts' and beneficiaries' data excluded above, suppress contract rates based on the following rules:

File DV failure: Contracts that failed to submit the CY 2022 MTM Program Reporting Requirements data file or who had a missing DV score for MTM are listed as "CMS identified issues with this plan's data."

Section-level DV failure: Contracts that score less than 95% in DV for their CY 2022 MTM Program Reporting Requirements data are listed as "CMS identified issues with this plan's data."

Element-level DV failure: Contracts that score 95% or higher in DV for their CY 2022 MTM Program Reporting Requirements data but that failed at least one of the seven data elements are listed as "CMS identified issues with this plan's data."

Small size: Contracts that have not yet been suppressed and have fewer than 31 beneficiaries enrolled are listed as "Not enough data available."

Organizations can view their own plan reporting data validation results in HPMS (https://hpms.cms.gov/). From the home page, select Monitoring | Plan Reporting Data Validation.

Step 4: Calculate the rate for the remaining contracts using the following formula:
Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period / Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period, met the specified targeting criteria per CMS during the reporting period, weren't in hospice at any point during the reporting period, and

who were enrolled in the MTM program for at least 60 days during the reporting period. Beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time in the measurement year are included in the denominator and the numerator if they received a CMR within this timeframe. Beneficiaries are excluded from the measure calculation if they were enrolled in the contract's MTM program for less than 60 days and did not receive a CMR within this timeframe.

Attachment O: Methodology for the Puerto Rico Model

Puerto Rico has a unique health care market with a large percentage of low-income individuals in both Medicare and Medicaid and a complex legal history that affects the health care system in many ways. Puerto Rican beneficiaries are not eligible for LIS. The categorization of contracts into final adjustment categories for the Categorical Adjustment Index (CAI) relies on both the use of a contract's percentages of beneficiaries with Low Income Subsidy/Dual Eligible (LIS/DE) and disabled beneficiaries. Since the percentage of LIS/DE is a critical element in the categorization of contracts to identify the contract's CAI, an additional adjustment is done for contracts that solely serve the population of beneficiaries in Puerto Rico to address the lack of LIS. The additional analysis for the adjustment results in a modified percentage of LIS/DE beneficiaries that is subsequently used to categorize the contract in its final adjustment category for the CAI.
The contract-level modified LIS/DE percentages for Puerto Rico contracts for the 2024 Star Ratings are developed using the following sources of information:

- The 2021 1-year American Community Survey (ACS) estimates for the percentage of people living below the Federal Poverty Level (FPL).
- The 2021 ACS 5-year estimates for the percentage of people living below 150% of the FPL; for Puerto Rico and for the 10 poorest US states (which may include the District of Columbia).
- The Medicare enrollment data file for those enrolled during 2022 provided for beneficiaries who were alive at least through December 2022, the percentage of each contract's beneficiaries who were DE, and for non-Puerto Rico contracts, the percentage who were LIS/DE. Beneficiary DE status was determined using a) the monthly beneficiary dual status codes, b) identification of Low Income Part D enrollees who reside in the US Territories, and c) beneficiaries with Medicaid coverage/who are Medicaid eligible by the Point of Sale contractor. For non-Puerto Rico contracts, beneficiaries who were LIS were determined using the monthly beneficiary LIS status codes, and beneficiaries were classified LIS/DE by combining the beneficiaries identified as DE and beneficiaries identified as LIS.

The following steps are employed to determine the modified percentages of LIS/DE for MA contracts solely serving the population of beneficiaries in Puerto Rico. All references to contracts in Puerto Rico are limited to the contracts solely serving the population of beneficiaries in Puerto Rico.

- The 10 states with the highest proportion of people living below the FPL are identified, based on 2021 1-year data from ACS (https://www.census.gov/content/dam/Census/library/publications/2022/acs/acsbr22-014.pdf, see Table 1). *The states identified are: Alabama, Arkansas, District of Columbia, Kentucky, Louisiana, Mississippi, New Mexico, Oklahoma, South Carolina, and West Virginia.*
- Data are aggregated from Medicare Advantage contracts that had at least 90% of their beneficiaries enrolled with mailing addresses within the 10 highest poverty states identified in step (1).
  For the 2024 Star Ratings adjustment, the data used for the model development included a total of 92 Medicare Advantage contracts with at least 90% of their beneficiaries with mailing addresses in one of the ten poorest states listed above.
- A linear regression model is developed using the known LIS/DE percentage and the corresponding DE percentage from the MA contracts in the 10 highest poverty states with at least 90% of their beneficiaries with mailing addresses in one of the ten states.
- The model for Puerto Rico is developed using the model in step (3) as its base.

  The estimated slope from the linear fit in the previous step (3) is retained to approximate the expected relationship between LIS/DE for each contract in Puerto Rico and its DE percentage. However, as Puerto Rico contracts are expected to have a larger percentage of low-income beneficiaries, the intercept term is adjusted to be more suitable for use with Puerto Rico contracts as follows:

  The intercept term for the Puerto Rico model is estimated by assuming that the Puerto Rico model will pass

through the point (x, y) where x is the observed average DE percentage in the Puerto Rico contracts, and y is the expected average percentage of LIS/DE in Puerto Rico. The expected average percentage of LIS/DE in Puerto Rico (the y value) is not observable but is estimated by multiplying the observed average percentage of LIS/DE in the 10 highest poverty states identified in step (1) by the ratio based on the 2021 5-year ACS estimates of the percentage living below 150% of the FPL in Puerto Rico compared to the corresponding percentage in the 10 poorest US states.

- To obtain each Puerto Rico contract's modified LIS/DE percentage, a contract's observed DE percentage is used in the Puerto Rico model developed in the previous step (4).

  A contract's observed DE percentage is multiplied by the slope estimate, and then, the newly derived intercept term is added to the product. The estimated modified LIS/DE percentage is capped at 100%. Any estimated LIS/DE percentage that exceeds 100% is categorized in the final adjustment category for LIS/DE with an upper bound of 100%.

  Note that the District of Columbia is included with the 50 US states when determining the 10 poorest in 2021. All estimated modified LIS/DE values for Puerto Rico are rounded to six decimal places when expressed as a percentage. (This rounding rule aligns with the limits for the adjustment categories for LIS/DE for the CAI.)

Model

The generic model developed to estimate a contract's LIS/DE percentage using its DE percentage is as follows:

$$\widehat{\text{LIS/DE}} = (\text{Slope} \times \text{contract's DE percentage}) + (\text{intercept})$$

Using the data from the 10 highest poverty states, the estimated slope was calculated to be 0.930021.

$$\widehat{\text{LIS/DE}} = (0.930021 \times \text{contract's DE percentage}) + (\text{intercept})$$

Next, the intercept for the Puerto Rico model was determined using the point (x, y) where x is the observed average DE percentage in Puerto Rico contracts (29.200398%) and y is an estimated expected average percentage of LIS/DE in Puerto Rico.

To calculate the estimated expected average percentage of LIS/DE in Puerto Rico, the observed average percentage of LIS/DE in the 10 poorest US states identified in step (1) is multiplied by the ratio of the percentage of Puerto Rico residents living below 150% of the FPL to the analogous percentage in the 10 poorest US states.

Description	Value
Percent of PR residents below 150% of FPL	59.500000%
Percent of residents in the 10 poorest US states below 150% of FPL	26.539801%
Observed average LIS/DE percentage in the 10 poorest US states	39.159485%
Observed average DE percentage in Puerto Rico contracts	29.200398%

The product thus becomes $\left(39.159485 \times \frac{59.500000}{26.539801}\right)$.

The new intercept for the Puerto Rico model is as follows:

$$\text{new intercept} = \left(39.159485 \times \frac{59.500000}{26.539801}\right) - (0.930021 \times 29.200398)$$

The final model to estimate the percentage of LIS/DE in Puerto Rico model is as follows:

$$\widehat{\text{LIS/DE}} = (0.930021 \times \text{contract's DE percentage}) + \left(39.159485 \times \frac{59.500000}{26.539801}\right) - (0.930021 \times 29.200398)$$

Example

To calculate the contract-level modified LIS/DE percentage for a hypothetical contract from Puerto Rico with an observed DE percentage of 25%, the value of 25.000000% is used in the model developed.

$$\widehat{\text{LIS/DE}} = (0.930021 \times \text{contract's DE percentage}) + \left(39.159485 \times \frac{59.500000}{26.539801}\right) - (0.930021 \times 29.200398)$$

The contracts percentage of 25.000000% is substituted into the Puerto Rico model.

$$\widehat{\text{LIS/DE}} = (0.930021 \times 25.000000) + \left(39.159485 \times \frac{59.500000}{26.539801}\right) - (0.930021 \times 29.200398)$$

The contract-level modified LIS/DE percentage for a hypothetical Puerto Rico contract that has an observed DE percentage of 25.000000% is 83.885811%.

The final adjustment category for the CAI adjustment is identified using the DE percentage of 25.000000% and the LIS/DE percentage 83.885811%.

Attachment P: Identification of Contracts Affected by Disasters

Natural disasters such as hurricanes and wildfires can directly affect Medicare beneficiaries and providers, as well as the Parts C and D organizations that provide them with important medical care and prescription drug coverage. These disasters may negatively affect the underlying operational and clinical systems that CMS relies on for accurate performance measurement in the Star Ratings program.

The 2024 Rate Announcement (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html) describes CMS's policy for making adjustments in the Star Ratings to take into account the effects of extreme and uncontrollable circumstances which occurred during the performance period. This is also codified in regulation at §422.166(i) and §423.186(i).

Operational Steps to Calculating Enrollment Impacted in Affected Contracts.

- Identify the areas which experienced both extreme and uncontrollable circumstances as defined in Section 1135 (g) of the Act and also are within a county or statistically equivalent entity, U.S. territory or tribal government designated in a major disaster declaration under the Stafford Act.
  - Areas where the Health and Human Services (HHS) Secretary exercised their authority under Section 1135 of the Act can be found at the Public Health Emergency website at https://www.phe.gov/emergency/news/healthactions/section1135/Pages/default.aspx
  - Major disaster areas are identified by the Federal Emergency Management Agency (FEMA) website at: https://www.fema.gov/disasters.

  Table P-1 lists the Section 1135 waivers issued by the HHS Secretary along with associated FEMA major disaster information that falls within the performance period for the 2024 Star Ratings.

Table P-1: Section 1135 waivers issued in relation to the FEMA major disaster declarations

Section 1135 Waiver Date Issued	Waiver or Modification of Requirements Under Section 1135 of the Social Security Act	FEMA Incident Type	Affected State	Incident Start Date
5/9/2022	New Mexico Wildfires and Straight-line Winds	Wildfires	New Mexico	4/5/2022
8/2/2022	Kentucky Severe Storms, Flooding, Landslides, and Mudslides	Severe Storms, Flooding, Landslides, and Mudslides	Kentucky	7/26/2022
9/20/2022	Tropical Storm/Hurricane Fiona	Hurricane	Puerto Rico	9/17/2022
9/26/2022	Hurricane Ian	Hurricane	Florida	9/23/2022
9/30/2022	Hurricane Ian	Hurricane	South Carolina	9/25/2022

- Identify the counties or statistically equivalent entities which were declared as Individual Assistance areas by each of the FEMA major disaster declarations that meet the criteria set out in Step 1 below.

Table P-2 lists all of the relevant FEMA major disaster declarations along with the state and associated Individual Assistance counties.

Table P-2: Individual Assistance counties in FEMA Major Disaster Declared States

FEMA Declaration	State	FEMA Individual Assistance Counties or County-Equivalents
DR-4652- NM	New Mexico	Colfax, Lincoln, Mora, San Miguel, Valencia
DR-4663-KY	Kentucky	Breathitt, Clay, Floyd, Knott, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley
DR-4671-PR	Puerto Rico	Adjuntas, Aguada, Aguadilla, Aguas Buenas, Aibonito, Anasco, Arecibo, Arroyo, Barceloneta, Barranquitas, Bayamon, Cabo Rojo, Caguas, Camuy, Canovanas, Carolina, Catano, Cayey, Ceiba, Ciales, Cidra, Coamo, Comerio, Corozal, Culebra, Dorado, Fajardo, Florida, Guanica, Guayama, Guayanilla, Guaynabo, Gurabo, Hatillo, Hormigueros, Humacao, Isabela, Jayuya, Juana Diaz, Juncos, Lajas, Lares, Las Marias, Las Piedras, Loiza, Luquillo, Manati, Maricao, Maunabo, Mayaguez, Moca, Morovis, Naguabo, Naranjito, Orocovis, Patillas, Penuelas, Ponce, Quebradillas, Rincon, Rio Grande, Sabana Grande, Salinas, San German, San Juan, San Lorenzo, San Sebastian, Santa Isabel, Toa Alta, Toa Baja, Trujillo Alto, Utuado, Vega Alta, Vega Baja, Vieques, Villalba, Yabucoa, Yauco
DR-4673-FL	Florida	Brevard, Charlotte, Collier, DeSoto, Flagler, Glades, Hardee, Hendry, Highlands, Hillsborough, Lake, Lee, Manatee, Monroe, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Sarasota, Seminole, St. Johns, Volusia
DR-4677-SC	South Carolina	Charleston, Georgetown, Horry

- Identify the service area at the state/county level for each contract in operation during the performance period. The service area of some organization types rated in the Star Ratings are not defined at the state/county level, so their service area must be transformed to include all states and counties covered by their service area.

Table P-3 lists how the service area for each organization type rated in the Star Ratings is defined and what transformation, if any, is needed to create a common state/county level file for all contracts.

Table P-3: Organization type service areas and necessary transformations

Star Rating Organization Types	How Service Area is defined	How Service Area is transformed
1876 Cost, E-CCP, E-PDP, E-PFFS, Local CCP, MSA, PFFS, R-PFFS & R-CCP	State/County	Not necessary, service area is defined at the state/county level
Regional CCP	MA Region	A record is created for each state/county within the MA region
PDP	PDP Region	A record is created for each state/county within the PDP region

- Compare the Individual Assistance states and counties from Step 2 below to the service area from all contracts created in Step 3 below with the state and counties. Create a list of all contracts which have any county that matches in both lists.
- Create a second list of all contracts that do not share any service area with the Individual Assistance counties, so that information on the status of all contracts is accounted for during the performance period.
- Identify the timeframe for each disaster and the associated enrollment files. Each of the disasters occurred during a specific period of time. Since the enrollment in a contract is constantly changing, CMS used the enrollment the contract was paid for in a month that as closely matched the disaster period in the specific state/county as possible for all further processing, following the months in the table below.

Table P-4 shows each of the disasters where relief was granted along with the disaster start date, and the enrollment file month that was used for that specific disaster. The enrollment file choice was based on the enrollment file cut-off date the file was created.

Table P-4: Major Disasters with associated enrollment months

FEMA Declaration	State	Start Date	Enroll File	Enroll Cut Off
DR-4652-NM	New Mexico	4/5/2022	May 2022	April 8, 2022
DR-4663-KY	Kentucky	7/26/2022	September 2022	August 5, 2022
DR-4671-PR	Puerto Rico	9/17/2022	October 2022	September 9, 2022
DR-4673-FL	Florida	9/23/2022	November 2022	October 7, 2022
DR-4677-SC	South Carolina	9/25/2022	November 2022	October 7, 2022

- Calculate disaster impacted enrollment for contracts experiencing multiple disasters. Because the contracts serve areas of different sizes and can sometimes serve large, diverse areas, it is common for a contract to be affected by more than one of the disasters. To account for this, CMS averaged the county/state level enrollments from each of corresponding enrollment periods in which the contract was affected.

Table P-5 shows an example where all possible enrollment periods are accounted for and how the enrollment for a contract in a state/county which matched the contract's service area state/county was calculated. Enrollment in out of service area state/counties was not included.

Table P-5: How enrollment periods were combined for contracts experiencing multiple disasters

Formula ID	Enrolled 202X_10	Enrolled 202X_11	Enrolled 202X_12	Enrollment Used
B	True	True	True	(202X_10 + 202X_11 + 202X_12) / 3
C	True	True		(202X_10 + 202X_11) / 2
F	True		True	(202X_10 + 202X_12) / 2
H	True			202X_10
J		True	True	(202X_11 + 202X_12) / 2
L		True		202X_11
N			True	202X_12
P				0 (zero)

- Using the enrollment for the contract developed in Step 7 below, take the sum of the enrollment in the entire service area for the contract to be used in further processing.
- Using the enrollment for the contract developed in Step 7 below, take the sum of the enrollment in all of the Individual Assistance counties that correspond to the contract service area.
- Using the final list of affected contracts from Step 4 below, calculate the percentage of the contract's total service area enrollment that was affected by the Individual Assistance area enrollment. Create flags for the ≥25% and ≥60% thresholds for processing of the ratings data for those contracts.

Example:

Steps 1 and 2 use the disasters and counties that have already been defined in Tables P-1 & P-2. For Steps 3 through 10, we use an example contract, HAAAA, which offers services to some counties from both California and Texas.

Step 3, Table P-6 below contains the full list of counties that make up the service area for contract HAAAA.

Step 4, the Individual Assistance County column is included in Table P-6. Rows marked TRUE are matches from Individual Assistance counties in the disasters for year 202X and the service areas of HAAAA. The rows marked FALSE were not Individual Assistance counties for any of the disasters in HAAAA.

Step 5, since the example contract HAAAA has service areas that coincide with disaster counties, it is not included in the list of contracts not affected.

Step 6, there are two separate enrollment periods associated with the disasters that match example contract HAAAA's service area. Those enrollment periods are 202X/09 & 202X/11. Columns for all enrollment periods are included in Table P-6, but only the valid enrollment periods contain the necessary data.

Step 7, the average enrollment is calculated for the included enrollment periods. The result of each average enrollment calculation for each county in the example contract's service area is shown in the final column of Table P-6.

Table P-6: Example Contract HAAAA's Service Areas and Enrollment during Relevant Disasters

FIPS Code	County Name	ST CD	EGHP County	Individual Assistance County	Enrolled 202X/09	Enrolled 202X/10	Enrolled 202X/11	Average Enrollment
06003	Alpine	CA	No	FALSE	8	-	8	8
06009	Calaveras	CA	No	FALSE	849	-	850	850
06011	Colusa	CA	No	FALSE	168	-	166	167
06015	Del Norte	CA	No	FALSE	369	-	360	364
06023	Humboldt	CA	No	FALSE	702	-	710	706
06045	Mendocino	CA	No	TRUE	428	-	429	428
06049	Modoc	CA	No	FALSE	157	-	158	158
06063	Plumas	CA	No	FALSE	182	-	181	182
06093	Siskiyou	CA	No	FALSE	798	-	800	799
06105	Trinity	CA	No	FALSE	150	-	150	150
48043	Brewster	TX	Yes	FALSE	16	-	15	16
48047	Brooks	TX	Yes	FALSE	28	-	27	28
48049	Brown	TX	Yes	FALSE	64	-	65	64
48057	Calhoun	TX	Yes	TRUE	28	-	28	28
48093	Comanche	TX	Yes	FALSE	33	-	32	32
48103	Crane	TX	Yes	FALSE	8	-	8	8
48109	Culberson	TX	Yes	FALSE	3	-	3	3
48123	DeWitt	TX	Yes	TRUE	26	-	26	26
48131	Duval	TX	Yes	FALSE	30	-	28	29
48133	Eastland	TX	Yes	FALSE	64	-	62	63
48143	Erath	TX	Yes	FALSE	61	-	59	60

FIPS Code	County Name	ST CD	EGHP County	Individual Assistance County	Enrolled 202X/09	Enrolled 202X/10	Enrolled 202X/11	Average Enrollment
48163	Frio	TX	Yes	FALSE	43	-	42	42
48171	Gillespie	TX	Yes	FALSE	17	-	17	17
48175	Goliad	TX	Yes	TRUE	18	-	18	18
48177	Gonzales	TX	Yes	TRUE	41	-	41	41
48237	Jack	TX	Yes	FALSE	35	-	34	34
48239	Jackson	TX	Yes	TRUE	30	-	30	30
48255	Karnes	TX	Yes	TRUE	19	-	19	19
48265	Kerr	TX	Yes	FALSE	85	-	86	86
48283	La Salle	TX	Yes	FALSE	25	-	25	25
48297	Live Oak	TX	Yes	FALSE	24	-	24	24
48301	Loving	TX	Yes	FALSE	0	-	0	0
48311	McMullen	TX	Yes	FALSE	4	-	4	4
48321	Matagorda	TX	Yes	TRUE	144	-	140	142
48323	Maverick	TX	Yes	FALSE	160	-	156	158
48371	Pecos	TX	Yes	FALSE	20	-	21	20
48377	Presidio	TX	Yes	FALSE	50	-	49	50
48389	Reeves	TX	Yes	FALSE	8	-	8	8
48391	Refugio	TX	Yes	TRUE	21	-	21	21
48443	Terrell	TX	Yes	FALSE	9	-	9	9
48463	Uvalde	TX	Yes	FALSE	13	-	10	12
48469	Victoria	TX	Yes	TRUE	158	-	154	156
48475	Ward	TX	Yes	FALSE	15	-	15	15
48495	Winkler	TX	Yes	FALSE	20	-	20	20

Step 8, sum the average enrollment from all rows from Table P-6. The total comes out to 5,120 for contract HAAAA.

Step 9, sum the average enrollment from all the rows from Table P-6 where the Individual Assistance counties is TRUE for contract HAAAA. The Individual Assistance total comes out to 909.

Step 10, calculate the final percentage for contract HAAAA. (909 / 5,120) * 100 = 17.753906 = 18%. Both flags for >=25% and >=60% are set to false since the example contract did not meet those thresholds.

Attachment Q: Missing Data Messages

CMS uses a standard set of messages in the Star Ratings when there are no numeric data available for a contract. This attachment provides the rules for assignment of those messages in each level of the Star Ratings.

Measure level messages

Table Q-1 contains all of the possible messages that could be assigned to missing data at the measure level.

Table Q-1: Measure level missing data messages

Message	Measure Level
Coming Soon	Used for all measures in MPF between Oct 1 and when the actual Star Rating data go live
Medicare shows only a Star Rating for this topic	Used in the numeric data for the Part C & D improvement measures in MPF and Plan Preview 2
Not enough data available	There were data for the contract, but not enough to pass the measure exclusion rules
CMS identified issues with this plan's data	Data were materially biased, erroneous and/or not reported by a contract required to report
Not Applicable	Used in the numeric data for the improvement measures in Plan Preview 1. In the HPMS Measure Star Page when a measure does not apply for a contract. When a Disenrollment Reasons Survey measure does not apply to the contract type.
Benefit not offered by plan	The contract was required to report this HEDIS measure but doesn't offer the benefit to members
Plan too new to be measured	The contract is too new to have submitted measure data
No data available	There were no data for the contract included in the source data for the measure
Plan too small to be measured	The contract had data but did not have enough enrollment to pass the measure exclusion rules
Plan not required to report measure	The contract was not required to report the measure

Assignment rules for Part C measure messages

Part C uses a set of rules for assigning the missing data message that varies by the data source. The rules for each data source are defined below.

Appeals (IRE) measures (C28 & C29):

Has CMS identified issues with the contract's data?
- Yes: Display message: CMS identified issues with this plan's data
- No: Is there a valid numeric measure rate?
  - Yes: Display the numeric measure rate
  - No: Is the contract effective date > 01/01/2022?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

CAHPS measures (C03, C19, C20, C21, C22, C23, & C24):

Is there a valid numeric CAHPS measure rate?
- Yes: Display the numeric CAHPS measure rate
- No: Is the contract effective date > 07/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Is the CAHPS measure rate NR?
    - Yes: Display message: Not enough data available
    - No: Is the CAHPS measure rate NA?
      - Yes: Display message: No data available
      - No: Display message: Plan too small to be measured

Call Center – Foreign Language Interpreter and TTY Availability measure (C30):

Is there a valid call center numeric rate?
- Yes: Display the call center numeric rate
- No: Is the organization type 1876 Cost, MSA, or Employer/Union Only Direct Contract PDP?
  - Yes: Display message: Plan not required to report measure
  - No: Is the contract effective date > 01/01/2023?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (C25):

Is the contract effective date > 01/01/2022?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2022?
  - Yes: Display message: Not enough data available
  - No: Is there a valid numeric CTM rate?
    - Yes: Display the numeric CTM rate
    - No: Display message: No data available

HEDIS measures except PCR and TRC (C01, C02, C08 – C11, C14, C16, C18):

Was the contract required to report HEDIS?
- Yes: Was the contract enrollment < 500 in July 2022?
  - Yes: Display message: Plan too small to be measured
  - No: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Was a valid patient level detail file 1 submitted and the measure data usable?
      - Yes: Is the status NA?
        - Yes: Display message: Not enough data available
        - No: Was contract enrollment at least 500 but less than 1,000?
          - Yes: Is the measure reliability at least 0.7?
            - Yes: Display the HEDIS measure numeric rate
            - No: Display message: No data available
          - No: Display the HEDIS measure numeric rate
      - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS PCR 18 and older (C15)

Was the contract required to report HEDIS?
- Yes: Was the contract enrollment < 500 in July 2022?
  - Yes: Display message: Plan too small to be measured
  - No: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Was a valid patient level detail file 1 submitted and the measure data usable?
      - Yes: Is the combined denominator for the 18-64 and 65+ measures <150?
        - Yes: Display message: Not enough data available
        - No: Was contract enrollment at least 500 but less than 1,000?
          - Yes: Is the measure reliability at least 0.7?
            - Yes: Display the HEDIS measure numeric rate
            - No: Display message: No data available
          - No: Display the HEDIS measure numeric rate
      - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS TRC average (C17):

Was the contract required to report HEDIS?
- Yes: Was the contract enrollment < 500 in July 2022?
  - Yes: Display message: Plan too small to be measured
  - No: Is the audit designation for all four TRC measures R?
    - No: Is the audit designation for any of the four TRC measures BD, BR, or NR?
      - Yes: Display message: CMS identified issues with this plan's data
      - No: Is the audit designation for any of the four TRC measures NB?
        - Yes: Display message: Benefit not offered by plan
        - No: The audit designation for one of the four TRC measures is NQ. Display message: Plan not required to report measure
    - Yes: Was a valid patient level detail file 1 submitted and the measure data usable?
      - Yes: Is the status for any component of the TRC average measure NA?
        - Yes: Display message: Not enough data available
        - No: Was contract enrollment at least 500 but less than 1,000?
          - Yes: Is the measure reliability at least 0.7?
            - Yes: Display the HEDIS measure numeric rate
            - No: Display message: No data available
          - No: Display the HEDIS measure numeric rate
      - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS SNP measures (C06 & C07):

Is the organization type (1876 Cost, PFFS, MSA) or is SNP not offered in 2024?
- Yes: Display message: Plan not required to report measure
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Is there a valid HEDIS measure numeric rate?
      - Yes: What is the status?
        - NA: Display message: Not enough data available
        - R: Display the HEDIS measure numeric rate
      - No: Display message: No data available

HEDIS-HOS measures (C04, C12, & C13):

Is there a valid HEDIS-HOS numeric rate?
- Yes: Display the HEDIS-HOS numeric rate
- No: Is the contract effective date > 01/01/2021?
  - Yes: Display message: Plan too new to be measured
  - No: Is the February 2022 contract enrollment < 500?
    - Yes: Display message: Plan too small to be measured
    - No: Is there a HEDIS-HOS rate code?
      - Yes: Assign message according to value below:
        - NA: Display message: Not enough data available
        - NB: Display message: Benefit not offered by plan
      - No: Display message: No data available

Members Choosing to Leave the Plan (C26):

Is there a valid numeric voluntary disenrollment rate?
- Yes: Display the numeric voluntary disenrollment rate
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Plan Reporting SNP measure (C05):

Is the organization type (1876 Cost, PFFS, MSA) or is SNP not offered in 2024?
- Yes: Display message: Plan not required to report measure
- No: Is there a valid Plan Reporting numeric rate?
  - Yes: Display the Plan Reporting numeric rate
  - No: Were there Data Issues Found?
    - Yes: Display message: CMS identified issues with this plan's data
    - No: Is the contract effective date > 01/01/2022?
      - Yes: Display message: Plan too new to be measured
      - No: Display message: No data available

Improvement (Star Ratings) measure (C27):

Is there a valid improvement measure rate?
- Yes: Display message: Medicare shows only a Star Rating for this topic
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Assignment rules for Part D measure messages

CAHPS measures (D05, D06):

Is there a valid numeric CAHPS measure rate?
- Yes: Display the numeric CAHPS measure rate
- No: Is the contract effective date > 07/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Is the CAHPS measure rate NR?
    - Yes: Display message: Not enough data available
    - No: Is the CAHPS measure rate NA?
      - Yes: Display message: No data available
      - No: Display message: Plan too small to be measured

Call Center – Foreign Language Interpreter and TTY Availability measure (D01):

Is there a valid call center numeric rate?
- Yes: Display the call center numeric rate
- No: Is the organization type 1876 Cost?
  - Yes: Display message: Plan not required to report measure
  - No: Is the contract effective date > 01/01/2023?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (D02):

Is the contract effective date > 01/01/2022?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2022?
  - Yes: Display message: Not enough data available
  - No: Is there a valid numeric CTM rate?
    - Yes: Display the numeric CTM rate
    - No: Display message: No data available

Improvement (Star Ratings) measure (D04):

Is there a valid improvement measure rate?
- Yes: Display message: Medicare shows only a Star Rating for this topic
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Members Choosing to Leave the Plan (D03):

Is there a valid numeric voluntary disenrollment rate?
- Yes: Display the numeric voluntary disenrollment rate
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

MPF Price Accuracy measure (D07):

Is the contract effective date > 9/30/2022?
- Yes: Display message: Plan too new to be measured
- No: Does contract have at least 30 claims over the measurement period for the price accuracy index?
  - Yes: Display the numeric price accuracy rate
  - No: Is the organization type 1876 Cost and does not offer Drugs?
    - Yes: Display message: Plan not required to report measure
    - No: Display message: Not enough data available

Patient Safety measures – Adherence (D08 - D10) & SUPD (D12):

Does the contract offer Part D?

Yes*:* Is the contract effective date > 12/31/2022?
- Yes: Display message: Plan too new to be measured
- No: Does contract have 30 or fewer enrolled beneficiary member years (measure denominator)?
  - Yes: Display message: Not enough data available
  - No: Display numeric measure percentage

No: Plan not required to report measure

Patient Safety measure – MTM CMR (D11)

Is the contract effective date > 12/31/2022?
- Yes: Display message: Plan too new to be measured
- No: Is Part D offered?
  - Yes: Is there a numeric rate?
    - Yes: Display numeric measure percentage
    - No: Is there a Reason(s) for Display Message?
      - Yes: Display appropriate message per table Q-2
  - No: Display message: Plan not required to report measure

Table Q-2: MTM CMR Reason(s) for Display Message conversion

Reason(s) for Display Message	Star Ratings Message
Contract failed to submit file and pass system validation by the reporting deadline	CMS identified issues with this plan's data
Contract did not pass element-level DV for at least one element	CMS identified issues with this plan's data
Contract had missing score on MTM section DV	CMS identified issues with this plan's data
Contract scored less than 95% on MTM section DV	CMS identified issues with this plan's data
Contract had all plans terminate by validation deadline	No data available
Contract had no MTM enrollees to report	No data available
Contract has 0 Part D enrollees	No data available
Contract had 30 or fewer beneficiaries meeting denominator criteria	Not enough data available
Contract not required to submit MTM program	Not required to report

Domain, Summary, and Overall level messages

Table Q-3 contains all of the possible messages that could be assigned to missing data at the domain, summary, and overall levels.

Table Q-3: Domain, Summary, and Overall level missing data messages

Message	Domain Level	Summary & Overall Level
Coming Soon	Used for all domain ratings in MPF between Oct 1 and when the actual Star Rating data go live	Used for all summary and overall ratings in MPF between Oct 1 and when the actual Star Rating data go live
Not enough data available	The contract did not have enough rated measures to calculate the domain rating	The contract did not have enough rated measures to calculate the summary or overall rating
Plan too new to be measured	The contract is too new to have submitted measure data for a domain rating to be calculated	The contract is too new to have submitted data to be rated in the summary or overall levels

Assignment rules for Part C & Part D domain rating level messages

Part C & D domain message assignment rules:

Is there a numeric domain star?
- Yes: Display the numeric domain star
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Assignment rules for Part C & Part D summary rating level messages

Part C & D summary rating message assignment rules:

Is there a numeric summary rating star?
- Yes: Display the numeric summary rating star
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Assignment rules for overall rating level messages

Overall rating message assignment rules:

Is there a numeric overall rating star?
- Yes: Display the numeric overall rating star
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Disenrollment Reasons messages

The 2024 Star Ratings posted to the CMS downloadable Master Table and HPMS includes data collected from the Disenrollment Reasons Survey (DRS). The DRS data was not used at any point in the calculation of the Star Ratings. The data are provided for information only at this time and are shown in HPMS with the Star Ratings data and on the display page at http://go.cms.gov/partcanddstarratings.

Because there are instances where a contract does not have data to display, a set of rules was developed to assign messages where data was missing so the data area would not be left blank.
Table Q-4 contains all of the possible messages that could be assigned to missing data in the disenrollment reason data displayed in HPMS.

Table Q-4: Disenrollment Reason missing data messages

Message	Meaning
Not Applicable	Used when the DRS measure does not apply to the contract type
Not Available	Used when there is no numeric data available, or data reliability indicated the value should be suppressed
Plan too new to be measured	The contract is too new for data to be collected for the measure

Disenrollment Reasons message assignment rules:

Is the contract effective date > 1/1/2022?
- Yes: Display message: Plan too new to be measured
- No: Is there numeric data for the contract in this DRS measure?
  - Yes: Did the data reliability check indicate the data should be suppressed?
    - Yes: Display message: Not Available
    - No: Display the numeric DRS rate
  - No: Does the DRS measure apply to the organization type
    - Yes: Display message: Not Available
    - No: Display message: Not Applicable

AEP	The annual period from October 15 until December 7 when a Medicare beneficiary can enroll into a Medicare Part C or D plan or re-enroll into their existing Medicare Part C or D Plan or change into another Medicare plan is known as the Annual Election Period (AEP). The chosen Medicare Part C or D plan coverage begins on January 1st.
C-SNP	Chronic Condition Special Needs Plans (C-SNPs) are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2.
CAHPS	The term CAHPS refers to a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care. CAHPS surveys probe those aspects of care for which consumers and patients are the best and/or only source of information, as well as those that consumers and patients have identified as being important. CAHPS initially stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the acronym now stands for Consumer Assessment of Healthcare Providers and Systems.
CCP	A Coordinated Care Plan (CCP) is a health plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by CMS. The CCP network is approved by CMS to ensure that all applicable requirements are met, including access and availability, service area, and quality requirements. CCPs may use mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care. CCPs include HMOs, PSOs, local and regional PPOs, and senior housing facility plans. SNPs can be offered under any type of CCP that meets CMS's requirements.
Cohort	A cohort is a group of people who share a common designation, experience, or condition (e.g., Medicare beneficiaries). For the HOS, a cohort refers to a random sample of Medicare beneficiaries that is drawn from each Medicare Advantage Organization (MAO) with a minimum of 500 enrollees and surveyed every spring (i.e., a baseline survey is administered to a new cohort each year). Two years later, the baseline respondents are surveyed again (i.e., follow up measurement). For data collection years 1998-2006, the MAO sample size was 1,000. Effective 2007, the MAO sample size was increased to 1,200.
Cost Plan	A plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan in accordance with a cost reimbursement contract under §1876(h) of the Act. In the Star Ratings, CMS classifies a Cost Plan not offering Part D as MA-Only and a Cost Plan offering Part D as MA-PD.
D-SNP	Dual Eligible Special Needs Plans (D-SNPs) enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Disability Status	Based on the original reason for entitlement for Medicare (Disability insurance benefits or both Disability insurance benefits and End-Stage Renal Disease).
Dual eligibles	Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.
Euclidean distance	The absolute value of the difference between two points, x-y.
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
HOS	The Medicare Health Outcomes Survey (HOS) is the first patient reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS program is to gather valid, reliable, and clinically meaningful health status data in the Medicare Advantage (MA) program for use in quality improvement activities, pay for performance, program oversight, public reporting, and improving health. All managed care organizations with MA contracts must participate.
I-SNP	Institutional Special Needs Plans (I-SNPs) are SNPs that restrict enrollment to institutionalized special needs individuals defined in 42 CFR 422.2.
IRE	The Independent Review Entity (IRE) is an independent entity contracted by CMS to review Medicare health and drug plans' adverse reconsiderations of organization determinations.
LIS	The Low Income Subsidy (LIS) from Medicare provides financial assistance for beneficiaries who have limited income and resources. Those who receive the LIS get help paying for their monthly premium, yearly deductible, prescription coinsurance, and copayments and they will have no gap in coverage.
LIS/DE	Beneficiaries who qualify at any point in the year for a low income subsidy through the application process and/or who are full or partial Dual (Medicare and Medicaid) beneficiaries.
MA	A Medicare Advantage (MA) organization is a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.
MA-Only	An MA organization that does not offer Medicare prescription drug coverage.
MA-PD	An MA organization that offers Medicare prescription drug coverage and Part A and Part B benefits in one plan.
MSA	Medicare Medical Savings Account (MSA) plans combine a high deductible MA plan and a medical savings account (which is an account established for the purpose of paying the qualified medical expenses of the account holder).
Percentage	A part of a whole expressed in hundredths. For example, a score of 45 out of 100 possible points is the same as 45%.

Percentile	The value below which a certain percent of observations fall. For example, a score equal to or greater than 97 percent of other scores attained on the same measure is said to be in the 97th percentile.
PDP	A Prescription Drug Plan (PDP) is a stand-alone drug plan, offered by insurers and other private companies to beneficiaries who receive their Medicare Part A and/or B benefits either through the Original Medicare Plan, Medicare Private Fee-for-Service Plans that do not offer prescription drug coverage, or Medicare Cost Plans that do not offer Medicare prescription drug coverage.
PFFS	Private Fee-for-Service (PFFS) is defined as an MA plan that pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; does not vary the rates for a provider based on the utilization of that provider's services; and does not restrict enrollees' choices among providers who are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment. The Medicare Improvements for Patients and Providers Act (MIPPA) added that although payment rates cannot vary based solely on utilization of services by a provider, a PFFS plan is permitted to vary the payment rates for a provider based on the specialty of the provider, the location of the provider, or other factors related to the provider that are not related to utilization. Furthermore, MIPPA also allows PFFS plans to increase payment rates to a provider based on increased utilization of specified preventive or screening services. See section 30.4 of the Medicare Managed Care Manual Chapter 1 for further details on PFFS plans.
Reliability	A measure of the fraction of the variation among the observed measure values that is due to real differences in quality (“signal”) rather than random variation (“noise”). On a scale from 0 (all differences among plans are due to randomness of sampling) to 1 (every plan's quality is measured with perfect accuracy).
SNP	A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limits enrollment to special needs individuals. A special needs individual could be any one of the following: 1) an institutionalized individual, 2) a dual eligible beneficiary, or 3) an individual with a severe or disabling chronic condition, as specified by CMS. A SNP may be any type of MA CCP. There are three major types of SNPs: 1) Chronic Condition SNP (C-SNP), 2) Dual Eligible SNP (D-SNP), and 3) Institutional SNP (I-SNP).
Sponsor	An entity that sponsors a health or drug plan.
Statistical Significance	Statistical significance assesses how likely differences observed are due to chance when plans are actually the same. CMS uses statistical tests (e.g., t-test) to determine if a contract’s measure value is statistically significantly greater or less than the national average for that measure, or whether conversely the observed differences from the national average could have arisen by chance.
Sum of Squares	Method used to measure variation or deviation from the mean.
TTY	A teletypewriter (TTY) is an electronic device for text communication via a telephone line, used when one or more of the parties has hearing or speech difficulties.

Very Low Reliability	For CAHPS, an indication that reliability is less than 0.6, indicating that 40% or more of observed variation is due to random noise.

Attachment S: Health Plan Management System Module Reference

This attachment is designed to assist reviewers of the data displayed in HPMS (https://hpms.cms.gov) to understand the various pages and fields shown in the HPMS Star Ratings module. This module employs standard HPMS user access rights so that users can only see contracts associated with their user id.

HPMS Star Ratings Module

The HPMS Star Ratings module contains the Part C & Part D data and stars for all contracts that were rated in the ratings year along with much of the detailed data that went into the various calculations. To access the Star Ratings module you must be logged into HPMS. If you do not have access to HPMS, information on how to obtain access can be found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/Overview.html

Once you are logged into HPMS, from the home page, select *Performance Metrics* from the *Quality and Performance* menu; the Performance Metrics page will be displayed. If you do not see *Performance Metrics*, your user id does not have the correct access permissions; please contact CMSHPMS_Access@cms.hhs.gov From the Performance Metrics page, select *Reports* and then *Star Ratings and Display Measures* from the left side menu. The *Star Ratings and Display Measures* home page will be displayed.

On the *Star Ratings and Display Measures* home page, select *Star Ratings* as the Report Type and select a reporting period. The remainder of this attachment describes the HPMS pages available for the 2024 Star Ratings.

1. Measure Data page

The Measure Data page displays the numeric data for all Part C and Part D measures. This page is available during the first plan preview.

The first four columns contain contract identifying information. The remaining columns contain the measures which will display in MPF. There is one column for each of the Part C and Part D measures. The measure columns are identified by measure id and measure name. The row immediately above this measure information contains the domain name. The row immediately below the measure information contains the data time frame of the measure. All subsequent rows contain the data for all individual contracts associated with the user's login id. Table S-1 below shows a sample of the left hand most columns shown in HPMS.

Table S-1: Measure Data page sample

Medicare Star Ratings Report Card Master Table

				HD1: Staying Healthy: Screenings, Tests and Vaccines		
				C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine
Contract Number	Organization Marketing Name	Contract Name	Parent Organization	01/01/2022 - 12/31/2022	01/01/2022 - 12/31/2022	03/2023 - 06/2023
HAAAA	Market A	Contract A	PO A	Plan too new to be measured	Plan too new to be measured	Not enough data available
HBBBB	Market B	Contract B	PO B	Not enough data available	73%	81%
HCCCC	Market C	Contract C	PO C	63%	71%	80%

2. Measure Detail – CTM Summary page

The Measure Detail – CTM Summary page contains the underlying data used for the Part C and Part D Complaints (C25/D02) measures. This page is available during the first plan preview. Table S-2 below explains each of the columns displayed on this page.

Table S-2: Measure Detail – CTM Summary page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Total Number of Complaints	Number of non-excluded complaints for the contract
Complaint Average Enrollment	The average enrollment used in the final calculation
Complaints Less Than 800 Enrolled	Yes / No, Yes = average enrollment less than 800, No = average enrollment greater than or equal to 800

3. Measure Detail – Part C Appeals page

The Measure Detail – Part C Appeals page contains the case-level data of the non-excluded cases used in producing the Part C Appeals measures Plan Makes Timely Decisions about Appeals (C28) and Reviewing Appeals Decisions (C29). The data displayed on this page reflect the state of the appeals case at the time the data were pulled for use in the 2024 Star Ratings. This page is available during the first plan preview. Table S-3 below explains each of the columns displayed on this page.

Table S-3: Measure Detail – Part C Appeals page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
Appeal Number	The case ID assigned to the appeal request
Appeal Priority	The priority of the appeal (Std Pre-Service, Exp Pre-Service, Pre-Service B Drug, or Retro)
Status	The status of the appeal (Closed, Decided, Pending, Promoted, Remanded, Reopened, Requested)
Date Appeal Filed	The Date the Plan Reconsideration was requested, as reported by the Part C Plan
Corrected Appeal Date	The Date Appeal Filed, as determined by the IRE/QIC
Date File Received (QIC)	The Date the IRE/QIC received the Appeal from the Part C Plan
Level 1 Extension	Indicates if the contract took an extension during their processing of the reconsideration, as reported by the contract
Adjusted Plan Interval	The number of days between the Date Appeal Filed (or Corrected Appeal Date, if applicable) and the Date File Received (QIC) adjusted based on the Appeal Priority (Std Pre-Service, Exp Pre-Service, or Retro) and adjusted to account for 5 mailing days
Appeal Decision	Decision associated with the appeal: Dismiss Appeal, Dismissed – Plan Approved Coverage, Favorable (Overturn MCO Denial), Partially Favorable (Partly Overturn MCO Denial), Unfavorable (Uphold MCO Denial), Withdraw Appeal, Remand to Plan
Late Indicator	Indicates if the appeal case was considered late or not (0=Not Late, 1=Late)

4. Measure Detail – SNP CM page

The Measure Detail – SNP CM page contains the underlying data used in calculating the Part C SNP Care Management measure (C05). The formulas used to calculate the SNP CM measure are detailed in Attachment E. This page is available during the first plan preview. Table S-4 below explains each of the columns displayed on this page.

Table S-4: Measure Detail – SNP CM page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Number of new enrollees	Number of new SNP enrollees eligible for an initial assessment (Data Element A)
Number of enrollees eligible for an annual HRA	Number of SNP enrollees eligible for an annual reassessment (Data Element B)
Number of initial HRAs performed on new enrollees	Number of initial assessments performed on new SNP enrollees (Data Element C)
Number of annual reassessments performed	Number of annual reassessments performed on eligible SNP enrollees (Data Element F)
Total Number of SNP Enrollees Eligible	Final measure numerator (Data Elements A + B)
Total Number of Assessments Performed	Final measure denominator (Data Elements C + F)
Percent of Eligible SNP Enrollees Receiving an Assessment	Final measure score
Data Validation Score	The data validation score for the contract
Reason for Exclusion	Reason (if any) contract submitted data was not used to generate a score

5. Measure Detail – HEDIS page

The Measure Detail – HEDIS page contains the underlying data used in calculating the Part C HEDIS SNP Care for Older Adults measures, the Transitions of Care measure and the Plan All-Cause readmissions measure. The formulas used to calculate the SNP measures are detailed in Attachment E. The formula used to calculate the PCR measure is detailed in Attachment F. This page is available during the first plan preview. Table S-5 below explains each of the columns displayed on this page and Table S-6 explains the HEDIS audit designations.

Table S-5: Measure Detail – HEDISpage fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
PBP ID	The Plan Benefit Package number associated with the data
Measure ID	The Star Ratings measure ID that corresponds to the data in the given row
Measure Name	The measure name that corresponds to the data in the given row
Rate	The measure rate
Eligible Population	The measure eligible population
Observed Count	The measure observed count (only applicable for PCR)
Expected Count	The expected count (only applicable for PCR)
Denominator	The measure denominator
Audit Designation	The audit designation (the audit codes are defined in the next table)
Status	The status (the status codes are defined in the next table)
Average Plan Enrollment	The average enrollment in the PBP during 2022 (see section Contract Enrollment Data)

Table S-6: HEDIS 2022 Audit Designations and 2024 Star Ratings

Audit Designation	Status	NCQA Description	Resultant Star Rating
R	R	Reportable	Assigned 1 to 5 stars depending on reported value
BR	R or NA	Biased Rate	1 star, numeric data set to "CMS identified issues with this plan's data"
R	NA	Small Denominator	"Not enough data available"
NB	R or NA	No Benefit	"Benefit not offered by plan"
NR	R or NA	Not Reported	1 star, numeric data set to "CMS identified issues with this plan's data"
NQ	R or NA	Not Required	"Plan not required to report measure" (applies only to 1876 Cost in the PCRb measure)
UN		Un-Audited	Not possible in Star Ratings measures which only use audited data

6. Measure Detail – CTM page

The Measure Detail – CTM page contains the case level data of the non-excluded cases used in producing the Part C & Part D Complaints measure (C25/D02). This page is available during the first plan preview. Table S-7 below explains each of the columns displayed on this page.

Table S-7: Measure Detail – CTM page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Complaint ID	The case number associated with the complaint in the HPMS CTM module
Complaint Category	The complaint category code
CMS Issue	Is the complaint designated as a CMS issue? (Yes/No)
Category	The complaint category description of CMS or plan lead
Subcategory	The complaint subcategory description associated with this case
Subcategory — Other	The complaint additional subcategory description associated with this case
Contract Assignment / Reassignment Date	The date that complaints are assigned or re-assigned to contracts

7. Measure Detail – Disenrollment

The Measure Detail – Disenrollment page contains data that are used in calculating the Part C & Part D disenrollment measure (C26/D03). The page shows the denominator, unadjusted numerator and original rate received from the MBDSS annual report. It also contains the adjusted numerator and final rate after all members meeting the measure exclusion criteria described in the measure description have been removed. This page is available during the first plan preview. Table S-8 below explains each of the columns displayed on this page.

Table S-8: Measure Detail – Disenrollment page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
Number Enrolled	The number of all members in the contract from MBDSS annual report
Number Disenrolled	The number disenrolled with a disenrollment reason code of 11, 13, 14 or 99, from the MBDSS annual report
Original Rate	The disenrollment rate as calculated by the annual MBDSS report
Adjusted Disenrolled	The adjusted numerator when all members who meet the measure exclusion criteria are removed
Adjusted Rate	The final adjusted disenrollment rate used in the Star Ratings
>1000 Enrolled	Flag indicates contract non-employer group enrollment >1,000 members during the year or contracts that did not have any disenrollments meeting the inclusion criteria (True = Yes, False = No)

8. Measure Detail – DR (Disenrollment Reasons)

The Measure Detail – Disenrollment Reasons page contains the data from the Disenrollment Reasons Survey (DRS). The Disenrollment Reasons data are not used at any point in the calculations of the Star Ratings but are provided in HPMS for information only at this time. The data come from surveys sent to enrollees who disenrolled between 1/1/2022 and 12/31/2022. Scores are suppressed if they are measured with very low reliability (< 0.60) and not statistically different from the national mean. This page is available during the first plan preview. Table S-9 below explains each of the columns displayed on this page.

Table S-9: Measure Detail – Disenrollment Reasons page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
DR PGPPPNC	Disenrollment Reasons - Problems Getting the Plan to Provide and Pay for Needed Care (MA-PD, MA-Only)
DR PCDH	Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-Only)
DR FRD	Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-Only, PDP)
DR PPDBC	Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)
DR PGIHP	Disenrollment Reasons - Problems Getting Information and Help from the Plan (MA-PD, PDP)

9. Measure Detail – MTM page

The Measure Detail – MTM page contains each contract's underlying denominator and numerator after measure specifications have been applied to the plan-reported validated data to calculate the Part D MTM Program Completion Rate for CMR (D11). The formulas used to calculate the MTM measure are detailed in Attachment N. This page is available during the first plan preview. Table S-10 below explains each of the columns displayed on this page.

Table S-10: Measure Detail – MTM page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Total Part D Enrollees	The number of Part D enrollees in the contract (average monthly HPMS enrollment)
Total MTM Enrollees, All	The number of Part D enrollees enrolled in the contract's MTM program (as reported in the Part D MTM plan-reported data). Includes beneficiaries that had an enrollment start date anytime in the measurement period, regardless of age, hospice status, or duration of MTM enrollment. Excludes records where the MBI could not be mapped to a valid beneficiary or where the beneficiary was reported with multiple, conflicting records in the same contract's data.
Total MTM Enrollees, Targeted	The number of Part D enrollees enrolled in the contract's MTM program that met the specified targeting criteria per CMS-Part D requirements pursuant to §423.153(d) of the regulations (as reported in the Part D MTM plan-reported data). Includes beneficiaries that had an enrollment start date anytime in the measurement period, regardless of age, hospice status, or duration of MTM enrollment. Excludes records where the MBI could not be mapped to a valid beneficiary or where the beneficiary was reported with multiple, conflicting records in the same contract's data.
Total MTM Enrollees, Targeted, Adjusted	The number of Part D enrollees enrolled in the contract's MTM program that met the specified targeting criteria per CMS-Part D requirements pursuant to §423.153(d) of the regulations (as reported in the Part D plan-reported data) after measure specifications applied as detailed in Attachment N. (Measure Denominator)
Total MTM Enrollees, Targeted, Adjusted, Who Received a CMR	The number of beneficiaries from the denominator who received a CMR. (Measure Numerator)
MTM Program Completion Rate for CMR	The percent of MTM program enrollees who received a CMR. (Measure Numerator)/(Measure Denominator)
MTM Section Data Validation Score	Contract's score in data validation (DV) for their MTM Program Reporting Requirements data
Reason(s) for Display Message	Reason(s) for display message assignment (if applicable)

10. Measure Detail – CAHPS page

The Measure Detail – CAHPS page contains the underlying data used in calculating the Part C & D CAHPS measures: Annual Flu Vaccine (C03), Getting Needed Care (C19), Getting Appointments and Care Quickly (C20), Customer Service (C21), Rating of Health Care Quality (C22), Rating of Health Plan (C23), Care Coordination (C24), Rating of Drug Plan (D05), and Getting Needed Prescription Drugs (D06). This page is available during the first plan preview. Table S-11 below explains each of the columns displayed on this page.

Table S-11: Measure Detail – CAHPS page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
CAHPS Measure	The CAHPS measure identifier followed by the Star Ratings measure id in parenthesis
Reliability	The contract-level reliability of the measure data
Statistical Significance	The statistical significance of the measure data (Below Average, No Difference, Above Average)
Use N	The number of usable surveys with responses to the item, or at least one item of a composite
Mean Score on Original Scale	The mean score on the original survey response scale
Variance of Mean on Original Scale	The sampling variance of contract mean ("Mean score") on the original scale
Standard Error on Original Scale	The standard error of the contract mean ("Mean score") on the original scale; square root of "variance"
Scaled Mean	The contract mean score rescaled to a 0-100 scale
Scaled SE	The standard error of the 0-100 scaled mean
Base Group	Categories determined by the percentile cutoffs from the distribution of mean scores
Star Rating	Determined by the percentile cutoffs, statistical significance of the difference of the contract mean from the overall mean, the statistical reliability of the estimate, and standard error of the mean score

11. Calculation Detail – MD

The Calculation Detail – MD page contains the summary of service area and enrollment data used to calculate the percentages for use in the Major Disaster rules for the individual measures. This page is available during the first plan preview. Table S-12 below explains the columns displayed on this page.

Table S-12: Calculation Detail – MD page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
Disaster Flag 2022	Indicates if the contract was affected by a 2022 disaster or not (valid values "Affected", "Not Affected" or "Too New")
Total Cnty in SA 2022	The total number of counties in the contract's 2022 service area (SA)
Num Cnty IA 2022	The number of counties from the contract's total SA designated as FEMA Individual Assistance (IA) counties in a 2022 disaster
IA Enrolled 2022	The number of members residing in the contract SA designated FEMA IA counties in a 2022 disaster
Total Enrolled 2022	The total number of members residing in the contract's 2022 SA
IA % 2022	The percent of members living in IA areas in a 2022 disaster (IA Enrolled)/(Total Enrolled)
IA % Rounded 2022	The percent of members living in IA areas in a 2022 disaster rounded to an integer
greater than 25% 2022	Flag that indicates if the contract has met the 25% threshold for 2022 disasters (Yes: greater than or equal to 25%, No: less than 25%)
greater than 60% 2022	Flag that indicates if the contract has met the 60% threshold for 2022 disasters (Yes: greater than or equal to 60%, No: less than 60%)
Disaster Flag 2021	Indicates if the contract was affected by a 2021 disaster or not (valid values "Affected", "Not Affected" or "Too New")
Total Cnty in SA 2021	The total number of counties in the contract's 2021 service area (SA)
Num Cnty IA 2021	The number of counties from the contract's total SA designated as FEMA Individual Assistance (IA) counties in a 2021 disaster
IA Enrolled 2021	The number of members residing in the contract SA designated FEMA IA counties in a 2021 disaster
Total Enrolled 2021	The total number of members residing in the contract's 2021 SA
IA % 2021	The percent of members living in IA areas in a 2021 disaster (IA Enrolled)/(Total Enrolled)
IA % Rounded 2021	The percent of members living in IA areas in a 2021 disaster rounded to an integer
greater than or equal to 25% 2021	Flag that indicates if the contract has met the 25% threshold for 2021 disasters (Yes: greater than or equal to 25%, No: less than 25%)

12. Calculation Detail – CAI

The Calculation Detail – CAI page contains the enrollment data used to calculate the percentages for use in the Categorical Adjustment Index (CAI) to determine the Final Adjustment Categories for each of the summary and overall rating calculations. This page is available during the first plan preview. Table S-13 below explains the columns displayed on this page.

Table S-13: Measure Detail – CAI page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Puerto Rico Only	Does the contract's non-employer service area only cover Puerto Rico? Yes or No
Contract Type	The contract plan type used to compute the ratings
Part D Offered	Is Part D offered by the contract? Yes or No
Enrolled	The total number enrolled in the contract used to determine the % LIS/DE and % Disabled
Num LIS/DE	The number of LIS/DE enrolled in the contract
Num Disabled	The number of Disabled enrolled in the contract
% LIS/DE	The percent of LIS/DE in the contract
% Disabled	The percent Disabled in the contract
Part C LIS/DE Initial Group	The Part C LIS/DE initial group this contract is in
Part C Disabled Quintile	The Part C Disabled Quintile group this contract is in
Part C FAC	The Part C Final adjustment category this contract is in
Part C CAI Value	The CAI value that will be combined with the final Part C summary score prior to rounding to half stars
Part D MA-PD LIS/DE Initial Group	The Part D MA-PD LIS/DE initial group this contract is in
Part D MA-PD Disabled Quintile	The Part D MA-PD Disabled Quintile group this contract is in
Part D MA-PD FAC	The Part D MA-PD Final adjustment category this contract is in
Part D MA-PD CAI Value	The CAI value that will be combined with the final Part D MA-PD summary score prior to rounding to half stars
Part D PDP LIS/DE Quartile	The Part D PDP LIS/DE Quartile group this contract is in
Part D PDP Disabled Quartile	The Part D PDP Disabled Quartile group this contract is in
Part D PDP FAC	The Part D PDP Final adjustment category this contract is in
Part D PDP CAI Value	The CAI value that will be combined with the final Part D PDP summary score prior to rounding to half stars
Overall LIS/DE Initial Group	The overall LIS/DE initial group this contract is in
Overall Disabled Quintile	The overall disabled Quintile group this contract is in
Overall FAC	The overall final adjustment category this contract is in
Overall CAI Value	The CAI value that will be combined with the final overall score prior to rounding to half stars

13. Measure Detail – HEDIS LE page

The Measure Detail – HEDIS LE page contains the data used to calculate the reliability of the HEDIS measures (C01, C02, C08 – C11, C14 – C18) data for contracts with $\geq$ 500 and $<$ 1,000 members enrolled in July of the measurement year (July 01, 2022). This page is available during the second plan preview. Table S-14 below explains each of the columns displayed on this page.

Table S-14: Measure Detail – HEDIS LE page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
Measure ID	The Star Ratings measure that the other data on this row is associated with
Rate	The submitted HEDIS rate
Score	The rounded value used for the measure in the Star Ratings
Enrollment	The contract enrollment for July 2022
Reliability	The computed reliability for the contract measure
Usable	The computed reliability ≥ 0.7 and rate is used = True, reliability < 0.7 and rate was not used = False

14. Measure Detail – C MD Results

The Part C Disaster Results page displays the measure level data handling results for contracts which had ≥25% of their enrollment living in areas affected by major disasters during the measurement period. Only the measures where the disaster policy required a comparison between two ratings years are displayed in the data. This page is available during the second plan preview. Table S-15 below explains the columns displayed on this page.

Table S-15: Measure Detail – C MD Results

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Measure ID	The 2024 Star Ratings Part C measure ID
2023 Value	The numeric measure value for the contract from the 2023 Star Ratings
2023 Star	The measure star for the contract from the 2023 Star Ratings
2024 Value	The numeric measure value for the contract from the 2024 Star Ratings
2024 Star	The measure star for the contract from the 2024 Star Ratings
Final Value	The measure value to be used in the 2024 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2024 Star Ratings after the data handling policy for disasters was applied
Final From	The Star Ratings year where the final data for the measure came from

15. Measure Detail – D MD Results

The Part D Disaster Results page displays the measure level data handling results for contracts which had greater than or equal to 25% of their enrollment living in areas affected by major disasters during the measurement period. Only the measures where the disaster policy required a comparison between two ratings years are displayed in the data. This page is available during the second plan preview. Table S-16 below explains the columns displayed on this page.

Table S-16: Measure Detail – D MD Results

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Measure ID	The 2024 Star Ratings Part D measure ID
2023 Value	The numeric measure value for the contract from the 2023 Star Ratings
2023 Star	The measure star for the contract from the 2023 Star Ratings
2024 Value	The numeric measure value for the contract from the 2024 Star Ratings
2024 Star	The measure star for the contract from the 2024 Star Ratings
Final Value	The measure value to be used in the 2024 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2024 Star Ratings after the data handling policy for disasters was applied
Final From	The Star Ratings year where the final data for the measure came from

16. Measure Detail – C Improvement page

The Improvement page is constructed in a similar manner as the Measure Data page. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the results of the improvement calculation for the specific Part C measures. There is one column for each Part C measure. The measure columns are identified by measure id and measure name. There is an additional column to the right of the Part C measure columns which contains the final numeric Part C improvement score. This numeric result is described in Attachment I: "Calculating the Improvement Measure and the Measures Used."

The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains a flag (Included or Not Included) to show if the measure was used to calculate the final improvement measure. All subsequent rows contain the data associated with an individual contract. The possible results for Part C measure calculations are shown in Table S-17 below.

Table S-17: Part C Measure Improvement Results

Improvement Measure Result	Description
No significant change	There was no significant change in the values between the two years
Significant improvement	There was a significant improvement from last year to this year
Significant decline	There was a significant decline from last year to this year
Not included in calculation	There was only one year of data available so the calculation could not be completed
Not Applicable	The measure is not an improvement measure
Not Eligible	The contract did not have data in more than half of the improvement measures or was too new
Held Harmless	The contract had 5 stars in this measure last year and this year
Low reliability and low enrollment	The low-enrollment contract measure score did not have sufficiently high reliability

17. Measure Detail – D Improvement page

The Improvement page is constructed in a similar manner as the Measure Data page. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the results of the improvement calculation for the specific Part D measures. There is one column for each Part D measure. The measure columns are identified by measure id and measure name. There is an additional column to the right of the Part D measure columns which contains the final numeric Part D improvement score. This numeric result is described in Attachment I: "Calculating the Improvement Measure and the Measures Used."

The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains a flag (Included or Not Included) to show if the measure was used to calculate the final improvement measure. All subsequent rows contain the data associated with an individual contract. The possible results for Part D measure calculations are shown in Table S-18 below.

Table S-18: Part D Measure Improvement Results

Improvement Measure Result	Description
No significant change	There was no significant change in the values between the two years
Significant improvement	There was a significant improvement from last year to this year
Significant decline	There was a significant decline from last year to this year
Not included in calculation	There was only one year of data available so the calculation could not be completed
Not Applicable	The measure is not an improvement measure
Not Eligible	The contract did not have data in more than half of the improvement measures or was too new
Held Harmless	The contract had 5 stars in this measure last year and this year

18. Measure Stars page

The Measure Stars page displays the Star Rating for each Part C and Part D measure. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the measure stars which will display in MPF. There is one column for each of the Part C and Part D measures. The measure columns are identified by measure id and measure name. The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains the data time frame. All subsequent rows contain the data for all individual contracts associated with the user's login id. Table S-19 below shows a sample of the left hand most columns shown in HPMS.

Table S-19: Measure Stars page sample

Medicare Star Ratings Report Card Master Table

					HD1: Staying Healthy: Screenings, Tests and Vaccines		
					C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine
Contract Number	Organization Marketing Name	Contract Name	Parent Organization		01/01/2022 - 12/31/2022	01/01/2022 - 12/31/2022	03/2023 - 06/2023
HAAAA	Market A	Contract A	PO A	Plan too new to be measured	Plan too new to be measured	Not enough data available	
HBBBB	Market B	Contract B	PO B	Not enough data available	4	5	
HCCCC	Market C	Contract C	PO C	3	4	5	

19. Domain Stars page

The Domain Stars page displays the Star Rating for each Part C and Part D domain. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the domain stars which will display in MPF. There is one column for each of the Part C and Part D domains. The domain columns are identified by the domain id and domain name. All subsequent rows contain the stars associated with an individual contract. Table S-20 below shows a sample of the left hand most columns shown in HPMS.

Table S-20: Domain Star page sample

Medicare Star Ratings Report Card Master Table

Contract Number	Organization Marketing Name	Contract Name	Parent Organization	HD1: Staying Healthy: Screenings, Tests and Vaccines	HD2: Managing Chronic (Long Term) Conditions	HD3: Member Experience with Health Plan
HAAAA	Market A	Contract A	PO A	4	3	4
HBBBB	Market B	Contract B	PO B	3	3	3
HCCCC	Market C	Contract C	PO C	3	3	4

20. Part C Summary Rating page

The Part C Summary Rating page displays the Part C rating and data associated with calculating the final Part C summary rating. This page is available during the second plan preview. There are flags to indicate if the final rating came from the without improvement measures calculation. Table S-21 below explains each of the columns contained on this page.

Table S-21: Part C Summary Rating page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Contract Type	The contract plan type used to compute the ratings
SNP Plans	Does the contract offer a SNP? (Yes/No)
Major Disaster Percentage 2021	The percentage of members living in an Individual Assistance area in 2021 rounded to an integer
Major Disaster Percentage 2022	The percentage of members living in an Individual Assistance area in 2022 rounded to an integer
Number Measures Required	The minimum number of measures required to calculate a rating out all required for the contract type.
Number Missing Measures	The number of measures that were missing stars
Number Rated Measures	The number of measures that were assigned stars
Calculated Summary Mean	Contains the mean of the stars for rated measures
Calculated Variance	The variance of the calculated summary mean
Calculated Score Percentile Rank	Percentile ranking of Calculated Summary Mean
Variance Percentile Rank	Percentile ranking of Calculated Variance
Variance Category	The reward factor variance category for the contract (low, medium, or high)
Reward Factor	The calculated reward factor for the contract (0, 0.1, 0.2, 0.3, or 0.4)
Interim Summary	The sum of the Calculated Summary Mean and the Reward Factor
Part C Summary FAC	Part C summary final adjustment category for the contract
CAI Value	The Part C summary CAI value for the contract
Final Summary	The sum of the Interim Summary and the CAI Value

HPMS Field Label	Field Description
Improvement Measure Usage	Did the final Part C summary rating come from the calculation using the improvement measure? (Yes/No)
New Measure Usage	Did the final Part C summary rating come from the calculation using the new measures? (Yes/No)
2024 Part C Summary Rating	The final rounded 2024 Part C Summary Rating

21. Part D Summary Rating page

The Part D Summary Rating page displays the Part D rating and data associated with calculating the final Part D summary rating. This page is available during the second plan preview. There are flags to indicate if the final rating came from the without improvement measures calculation. Table S-22 below explains each of the columns contained on this page.

Table S-22: Part D Summary Rating View

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Contract Type	The contract plan type used to compute the ratings
Major Disaster Percentage 2021	The percentage of members living in an Individual Assistance area in 2021 rounded to an integer
Major Disaster Percentage 2022	The percentage of members living in an Individual Assistance area in 2022 rounded to an integer
Number Measures Required	The minimum number of measures required to calculate a rating out all required for the contract type
Number Missing Measures	The number of measures that were missing stars
Number Rated Measures	The number of measures that were assigned stars
Calculated Summary Mean	Contains the mean of the stars for rated measures
Calculated Variance	The variance of the calculated summary mean
Calculated Score Percentile Rank	Percentile ranking of Calculated Summary Mean
Variance Percentile Rank	Percentile ranking of Calculated Variance
Variance Category	The reward factor variance category for the contract (low, medium, or high)
Reward Factor	The calculated reward factor for the contract (0, 0.1, 0.2, 0.3, or 0.4)
Interim Summary	The sum of the Calculated Summary Mean and the Reward Factor
Part D Summary FAC	Part D summary final adjustment category for the contract
CAI Value	The Part D summary CAI value for the contract
Final Summary	The sum of the Interim Summary and the CAI Value
Improvement Measure Usage	Did the final Part D summary rating come from the calculation using the improvement measure? (Yes/No)
2024 Part D Summary Rating	The final rounded 2024 Part D Summary Rating

22. Overall Rating page

The Overall Rating page displays the overall rating for MA-PD contracts and data associated with calculating the final overall rating. This page is available during the second plan preview. There are flags to indicate if the final rating came from the without improvement measures calculation. Table S-23 below explains each of the columns contained on this page.

Table S-23: Overall Rating View

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Contract Type	The contract plan type used to compute the ratings
SNP Plans	Does the contract offer a SNP? (Yes/No)
Major Disaster Percentage 2021	The percentage of members living in an Individual Assistance area in 2021 rounded to an integer
Major Disaster Percentage 2022	The percentage of members living in an Individual Assistance area in 2022 rounded to an integer
Number Measures Required	The minimum number of measures required to calculate a rating out all required for the contract type
Number Missing Measures	The number of measures that were missing stars
Number Rated Measures	The number of measures that were assigned stars
2024 Part C Summary Rating	The 2024 Part C Summary Rating
2024 Part D Summary Rating	The 2024 Part D Summary Rating
Calculated Summary Mean	Contains the weighted mean of the stars for rated measures
Calculated Variance	The variance of the calculated summary mean
Calculated Score Percentile Rank	Percentile ranking of Calculated Summary Mean
Variance Percentile Rank	Percentile ranking of Calculated Variance
Variance Category	The reward factor variance category for the contract (low, medium, or high)
Reward Factor	The calculated reward factor for the contract (0, 0.1, 0.2, 0.3, or 0.4)
Interim Summary	The sum of the Calculated Summary Mean and the Reward Factor
Overall FAC	Overall final adjustment category for the contract
CAI Value	The Overall CAI value for the contract
Final Summary	The sum of the Interim Summary and the CAI Value
Improvement Measure Usage	Did the final overall rating come from the calculation using the improvement measures? (Yes/No)
New Measure Usage	Did the final overall rating come from the calculation using the new measures? (Yes/No)
2024 Overall Rating	The final 2024 Overall Rating

23. Low Performing Contract List

The Low Performing Contract List page displays the contracts that received a Low Performing Icon and the data used to calculate the assignment. This page is available during the second plan preview. HPMS users in contracting organizations will see only their own contracts in this list. None will be displayed if no contract in the organization was assigned a Low Performing Icon. Table S-24 below explains each of the columns contained on this page.

Table S-24: Low Performing Contract List

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Rated As	The type of rating for this contract, valid values are "MA-Only," "MA-PD," and "PDP"
2022 C Summary	The 2022 Part C Summary Rating earned by the contract
2022 D Summary	The 2022 Part D Summary Rating earned by the contract
2023 C Summary	The 2023 Part C Summary Rating earned by the contract
2023 D Summary	The 2023 Part D Summary Rating earned by the contract
2024 C Summary	The 2024 Part C Summary Rating earned by the contract
2024 D Summary	The 2024 Part D Summary Rating earned by the contract
Reason for LPI	The combination of ratings that met the Low Performing Icon rules. Valid values are "Part C," "Part D," "Part C and D," & "Part C or D." See the section titled "Methodology for Calculating the Low Performing Icon" for details.

24. High Performing Contract List

The High Performing Contract List page displays the contracts that received a High Performing Icon. This page is available during the second plan preview. HPMS users in contracting organizations will see only their own contracts in this list. None will be displayed if no contract in the organization was assigned a High Performing Icon. Table S-25 below explains each of the columns contained on this page.

Table S-25: High Performing Contract List

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Rated As	The type of rating for this contract, valid values are "MA-Only," "MA-PD," and "PDP"
Highest Rating	The highest level of rating that can be achieved for this organization, valid values are "Part C Summary," "Part D Summary," "Overall Rating"
Rating	The star value attained in the highest rating for the organization type

25. Technical Notes link

The Technical Notes link provides the user with a copy of the 2024 Star Ratings Technical Notes. A draft version of these technical notes is available during the first plan preview. The draft is then updated for the second plan preview, and then finalized when the ratings data have been posted to MPF. Other updates may occur to the technical notes if errors are identified outside of the plan preview periods and after MPF data release.

Left clicking on the Technical Notes link will open a new browser window which will display a PDF (portable document format) copy of the 2024 Star Ratings Technical Notes. Right clicking on the Technical Notes link will pop up a context menu which contains Save Target As…; clicking on this will allow the user to download and save a copy of the PDF document.

26. Medication NDC List

The Medication NDC List link provides the user a means to download a copy of the medication lists used for the Medication Adherence measures (D08 – D10) & SUPD (D12). This downloadable file is in Zip format and contains two Excel files.

27. Part C and Part D Example Measure Data

The Part C and Part D Example Measure Data link provides the user with a means to download a copy of the data for the Breast Cancer Screening Part C measure, and the Complaints about the Plan Part D measure and the MTM Program Completion Rate for CMR Part D measure for the full set of contracts used to calculate the cut points. The data are de-identified such that individual contract's data cannot be determined. The data include the measure value, a flag for contracts that had data issues, and two flags identifying contracts with >= 25 percent and >= 60 percent of enrollees living in an area affected by a disaster. There is also a flag in the Part C measure file to identify HEDIS low enrollment contracts. There is also a flag in the Part D measure files identifying contracts as MAPD or PDP. This downloadable is in Zip format and contains three Excel files.

Transcript of French Call

Scan Health Plan CSR: Thank you for calling Scan Health plan, this is [CSR name], who do I have the pleasure of speaking with?

Interviewer: Uh, French, I need French.

CSR: Yes of course, one moment please.

(Hold queue music.)

CSR: One moment please, I'm still trying to locate a translator.

(Hold queue music.)

Interpreter: [hard to hear] your interpreter, everything you say will remain secret and confidential.

CSR (overlapping): Yes thank you.

Interpreter: How may I help you?

CSR: I have someone on the line who speaks French, please go ahead.

Interpreter: Bonjour, je m'appelle [name of interpreter], je suis votre interprète de français, tout ce qui vous allez dire va rester secret et confidentiel.

(Translated into English): Hello, my name is [name of interpreter], I am your French interpreter, all that you are going to say will stay secret and confidential.

Interviewer : Oui, bonsoir, alors j'ai, j'ai une question –

(Translated into English): Yes, good evening, so I, I have a question -

Interpreter (overlapping): Bonsoir.

(Translated into English): Good evening.

Interviewer: Êtes-vous la…êtes-vous la personne adéquate pour répondre aux questions concernant les avantages médicaux de Village Health HMO-POS C-SNP ?

(Translated into English): Are you the…are you the right person to answer questions about health benefits of Village Health HMO-POS C-SNP?

Interpreter: Excusez, madame, j'ai…j'ai raté de prendre notes. Les avantages médicaux de Village, s'il vous plaît, si vous pourrez répéter ?

(Translated into English): Excuse me, ma'am, I…I failed to take notes. Health benefits of Village, if you will repeat please?

Interviewer: Oui, c'est le nom du plan. C'est Village Health, ensuite HMO-POS C-SNP.

(Translated into English): Yes, it's the name of the plan. It's Village Health, then HMO-POS C-SNP.

Interpreter: Are you the right person to answer questions about the plan Village Plus HMO-POS C-SNP?

CSR: Yes, of course, how may I assist you?

Interpreter: Bien sûr, qu'est-ce que je peux faire pour vous ?

(Translated into English): Of course, what can I do for you?

Interviewer: Thank you, this has been a test call for the Centers for Medicare and Medicaid Services. We have reached the time limit for this question. Have a good day.

CSR: Thank you, you too. Thank you, interpreter.

Interviewer (overlapping): Mm hmm.

Interpreter: Interpreter 069754 disconnecting, thank you for using our, our services.

Clarifications to Questions and Answers During the Webinar

Question: If the state relay operator [for TTY] is not available or accidentally drops the call, the call is still considered incomplete. Is that a correct statement?

Clarified Answer: The majority of the contracts opt to use the relay operator via 711 in lieu of using in-house TTY equipment, so we want to share additional information about the monitoring experience when using a relay operator. During the call, the 711 relay operator narrates what is happening via the TTY device for the contractor's test caller as they move through the call. That way, we can capture what is happening and report those metrics for each contract. Below is a description of how it works, and instances when a failure *is* or is *not* counted against the contract.

The test caller uses a TTY device to call 711. There is no ring limit for TTY calls to the relay operator.

If the call does not connect to the relay operator on the first attempt or they receive a busy signal, they turn the machine off, and turn it back on, and make a second attempt to connect via 711. If they cannot connect via 711 on the second attempt, they also have a toll-free number for the relay operator to be used for a third attempt. If the test caller uses the toll-free option in lieu of 711, they are trained to leave a comment in the call notes. For example, they might include this note, "Call did not go through with 711 and used 1-800-XXX-XXXX instead." If, after a third attempt, the test caller is not able to connect with a TTY relay operator, the inability to connect *is* reported and this *is* counted against the contract. Codes for reporting a failure to connect via TTY are available. For example, we might see code 296.19 (TTY Could Not Connect to Relay Operator) in the raw data results. *Rationale: We attempt to create an authentic experience of a Medicare beneficiary trying to receive assistance via a TTY device. Our policy is to report one unsuccessful call if, after three attempts, we cannot connect to the relay operator. The organization should use this feedback to evaluate its business policy for use of a relay operator in lieu of an in-house TTY device.*

Once our contractor connects on its TTY device with the relay operator at 711, we give 711 the plan's toll-free Part C or Part D prospective beneficiary customer service number to dial. There is no timer activated at this point. We ask the TTY operator to confirm the number he or she is dialing. Note: If the TTY operator dials the wrong number, the monitoring contractor opts to use the "do over" option available to try again. In this scenario, the invalidated call *is not* counted against the plan.

The operator will narrate what's happening by replying through the TTY device, e.g., he or she may type "ringing."
When answered, the relay operator will relay the next options: "Thank you for calling The Example Health Plan. Please hold for next representative," or relay the IVR options available. **At this point, the 7-minute TTY hold timer is initiated.**

The interviewer navigates through the IVR via the relay operator by telling the operator to select X in the IVR choices, or to say "representative." If the relay operator relays information to the test caller indicating that his or her call disconnected from the health plan when making the requested selection in the IVR, the disconnected call gets coded as such and this is counted in the results in the same manner that disconnected calls are counted for non-TTY calls. If the relay operator indicates there has been an extended hold time and asks if we wish to call back later, the test caller will state again, "No, please hold for a live CSR." The test caller will hold until a live CSR answers, or the 7-minute TTY hold timer expires.

If the call successfully connects with a live customer service representative who can respond "yes" to the introductory question ("Can you answer questions about Medicare Part C (or Part D) benefits?") before the 7-minute TTY HOLD timer expires, the survey continues and each of the randomly generated three accuracy questions is asked. A time stamp is set on exiting the test caller's screen so that the length of time to answer can be determined. The TTY_HOLD timer captures the time waiting for the live CSR to respond to the relay TTY operator. We then move to asking the first of three randomly generated accuracy questions. Each accuracy question has its own 7-minute timer.

If the relay operator stops responding via the TTY device at any point, this counts against the contract. Here is an example. Our test caller is communicating and types "GA" for "go ahead" on our TTY device and we receive no response in return. In this case, we remain on the line until the call times out. This is counted as unsuccessful in our test for TTY functionality because we have not had true communication in the process and are still awaiting an answer to our question. Rationale: Plans needs to know how members are affected when they attempt to contact their plan via a relay operator, especially if there are TTY functionality failures occurring during this process. We want plans to have this information so that they can make informed business decisions about processes that affect their membership.

Webinar Answer: I may have to defer the answer on that one. Let me touch base with the contractor. If the person who asked that question could send it to the Call Center Monitoring mailbox, I would appreciate it.

[Linda] I was just going to say exactly the same thing. Send it to the mailbox and we will give it careful thought, but in general we try not to hold you accountable for things outside of your control, so if it was obvious that it was dropped by the relay and that was a knowable event, we would strive not to count that against you.

[Chris] Let me say too that if the Call Center Monitoring contractor is placing a call and anything goes awry – they make the wrong IVR selection or whatever – they have the option to do what they call a redo, so it will stop that call and invalidate it. If they make an error, it does not count against you. It would just allow an opportunity for them to redo that call. So, please know that we try not to hold you accountable for anything that is not your fault

Question: Why is accuracy not included in the Star Ratings?

Clarified Answer: Upon research, we clarify that the accuracy measure results previously were part of the Star Ratings process. In the past, the majority of plans scored high ranks and that clustered the majority of plans together with similar results, so the measure itself was deemed to be not particularly helpful in differentiating one plan from another. It was then moved to a display measure rather than a Star Ratings measure.

Webinar Answer: This is a very deep question and probably beyond the scope of today's call. There are lots of reasons why things wind up in the call ratings. The only piece of the call center monitoring has been is the accessibility [of TTY and interpreter availability]. I think that it's a more objective study, perhaps, or it just happens to be historically that it was not included. If you really need to know, send us an email and we will go hunt down the powers that be on the Star Ratings team.

Q&A

Question: Is the accuracy test on the actual answer provided by the plan's CSR or on the quality of the interpreter to relay the answer in the foreign language?

Clarified Answer: One of the goals of the Accuracy & Accessibility Study, which is performed by testing interpreter availability, TTY functionality, and accuracy of the questions asked, is to determine if interpreters are available and to determine the accuracy of responses given to prospective members. So, we would separate the interpreter availability component from this question, as it is a given that an interpreter is available in this scenario. In regard to the accuracy questions, an interpreter must be able to respond to questions accurately, so if the interpreter did not do that correctly, this must be attributed to the plan's performance. If the response to the question is not relayed correctly due to the failure of the language interpreter with whom the plan contracted, we believe it is everyone's best interest to report that negative result back to the plan through the failure of the accuracy question being tested. Doing so helps inform the interpretation service's performance, and the plan can use that feedback for its future business decisions. In this scenario, we do not score or judge the interpreter's performance throughout the call – we are only looking for the correct response to the question. We would not hold the performance of the interpreter against the plan, generally speaking, so long as the response to the accuracy question is accurate. We are always happy to hear from any plan who believes a certain result may be unfair, and we are certainly willing to investigate issues that may arise, but in this instance described above, failure to respond accurately due to the failure of the interpreter is counted against the plan in the form of incorrect response to that the question being tested.

Webinar Answer: Our goal is not to test language translation's ability to translate language. That is a different test. Our hope and dream is that you are able to provide answers to them [callers]. If it is obvious that the interpreter on the line is not successfully interpreting – which means, I think, a native speaker often knows when something doesn't make sense in their language -- I don't think that we would count against you. I don't know if it gets documented, so I would have to look to Chris for that answer.

[Chris] Well, I would say too that the questions we are asking are more plan-specific questions so the real emphasis is that customer service representative be able to answer plan-specific questions, and that might be something on your formulary [for example]. It should be pretty straightforward. I wouldn't anticipate too many problems, but if you experience that and you need to come to us to say we don't think this is fair the way this was counted, reach out to me. We do have mechanisms where if you have the recorded conversation we can listen to it to see if there is a problem and check our own finish notes from our contractor's records and make a judgment call on that. If it is due to the failure strictly of the interpreter, I wouldn't hold that against you.

[Linda] I've never heard of that happening.

Q&A

Questions Asked of the Call Center Monitoring Mailbox after the Webinar

Q: Would you be able to provide further clarity as to the timeliness metric utilized? For example, if a CSR begins providing the answer at six and a half minutes and finishes after the seven (7) minute limit. Does this count as untimely? Please let me know if you would like further clarification to the inquiry posed.

A: I believe the best way to answer your question is to explain that the timers in place are all the same for the LEP HOLD timer used when waiting for an interpreter to assist the CSR with the introductory question, the TTY HOLD timer used when connecting via a TTY device, or for any of the three accuracy questions that each utilize a 7-minute timer. The test caller has a screen that has a timer on it that counts backward from 420 seconds (7 minutes x 60 seconds). When that timer goes off, the test caller does not have the ability to change the outcome of the call being ended, so yes, if someone was halfway through the answer, the result would be the same as if they had not begun to answer -- the timer goes off and the call is ended.

So, if we are determining interpreter availability, if we have not received a yes response to the introductory question before the timer goes off, that is counted as an untimely call for the interpreter availability measure.

When we have moved to the accuracy question, if a timer goes off, that has a neutral effect on the plans, meaning we have already had a completed call for the interpreter availability component, so that would count in a good way for the plan if that portion of the test was over, and the timer going off during the accuracy questions does not negatively impact the plan because at that stage we are determining the accuracy of the answer only, so not having enough time to reply is not normally a problem for accuracy questions 1-3, but if the timer goes off, it is neutral to the plan. There is no correct answer and no incorrect answer, in other words.

Q: Are the [Accuracy] questions that were used as part of the 2015 accuracy study published and available? I would like to pass them along to the Member Services staff to be used in training.

A: No, they are not published or available. To explain, we did not ask accuracy questions of traditional Medicare Advantage Plans and Prescription Drug Plans in 2015. Instead, we asked Medicare-Medicaid Plans (MMPs) accuracy questions that are specific to MMPS. So, at the conclusion of that study, the MMPs received their results and the informational notices they received at the end of the study shared the questions that were asked of their plans. So, those would not be helpful to traditional MAs or PDPs because they are separate questions based upon MMP benefits.
While I do not have the list of questions asked in the past to share, I can tell you that you will receive a listing of the questions asked following the 2016 study. Additionally, we emphasize that CSRs will be assisted if they are trained on plan-specific questions (For example, “What is my copay or coinsurance for a certain service?” and “Is a certain drug on the formulary?”). It may also help if CSRs are familiar with information in the 2016 version of Medicare & You, which is available here: https://www.medicare.gov/medicare-and-you/different-formats/m-and-y-different-formats.html

Q: I just want to confirm my understanding of how menu choices are handled when monitoring calls are made. When the menu includes an option for member services, this is the option that will be chosen for the monitoring - I am understanding that the caller would not choose options such as Behavioral Health crisis lines, provider lines or nurse lines.

A: Your understanding is correct. Our telephone interviewers will make an IVR/menu selection for member services whenever that is an available choice and we are testing either an enrollee Part C or Part D phone lines. We would not make selections for behavioral health lines, nurse lines, crisis lines, or other such choices. Our callers make appropriate IVR selections whenever possible.

I separated out the enrollee Part C and Part D lines above so that I could emphasize that we also call your pharmacy technical assistance help line as part of our Timeliness Study to measure average hold time and disconnect percentage rates. This line is intended for pharmacists or providers who need technical assistance, so in that case, we call the toll-free number you designate in HPMS and make appropriate IVR selections to direct us toward the goal of receiving an answer to this question: "Can you help me with questions about processing a Medicare Part D pharmacy claim?" This is slightly different than when we call enrollee lines for the Timeliness Study, or when we call prospective beneficiary customer service lines for the Accuracy & Accessibility Study.

Q: During the Q &A session after the webinar when the phone lines were unmuted, it was hard to hear the questions/answers. Could you please share your answer again for the question that pertained to what can be said by the answering service when the benefit department has closed for the evening (and what time frame is that permissible).

A: We did not specifically address what can or cannot be said by the answering service when the benefit department has closed, but I believe you are referring to what Linda said, which was a general comment in response to slide 70 on inclement weather. At that point, we were discussing plans/sponsors having back-up measures in place in case they needed to close a center, meaning maybe a call center in the East has to "shut down" due to weather by passing the baton to a call center in the West, or something like that. Linda stated that she has also heard of plans who contract with their pharmacy benefit manager (PBM) to answer calls after hours. She postulated that the PBM may be able to respond to any Part D/prescription drug questions that comes in but would most likely just answer the phone and say that center was closed at this time and take a message. I do not recall anything more being said about center closures and the messages that are left, as we on the Call Center Monitoring team do not oversee that sort of process or react to any sort of message, unless there was an instance where a call center message says they are closed at an inappropriate time. In that case, the contractor informs me and I reach out to the compliance officer to ask why it was closed during the required hours of operation. Ultimately, we can take compliance actions for inappropriate closures. Our experience shows that most often, the sponsors' and plans' Medicare call centers are open as required.

Q: Slide 35 & 36 are a bit confusing. Where is the 2 minute Average Speed of Answer (ASA/AHT)? The ASA would be calculated from the time the caller has left the IVR and waiting for the agent to pick up the line, is that correct? Or, does it also include the 30 second to answer the initial call?
Also, want to clarify, we believe the ASA should be after the 30 second for the line to connect and should be after the beneficiary has navigated through the IVR and is now in the hold queue waiting for agent to pick up. Is that correct (ASA, 2 min is while the beneficiary is in the hold queue (after moving through the IVR))?

A: Slides 35-36 may have been confusing because I used those to discuss the Accuracy & Accessibility Study (Survey II) where we measure interpreter and TTY availability as well as the accuracy of questions. The slide generally does apply to the average hold time of 2 minutes or less as well, which is measured during

the quarterly Timeliness Study (Survey I). We covered that during the start of the call when we had the most audio problems, so you may not have heard me say this.

Just to clarify, we do not measure anything specifically called the Average Speed of Answer. Our study measures the average hold time, which is likely the same, but wanted to point that out in case it is difference in your call center. The text below, provided during our presentation, should answer your question.

> Let's take a minute to discuss the **Average Hold Time**. The average hold time is defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person. Please be aware that time spent navigating the IVR system or touch tone response system does **not** count toward the average hold time. For calls in which our caller terminates the call due to being on hold greater than 10 minutes prior to reaching a live person, the hold time applied is 10 minutes. Contracts with an average hold time for each measure greater than 2 minutes are out of compliance with CMS standards.

Q: How can I receive the audio recording from the 2/3/2015 Webinar on Call Center Monitoring? I would like to share with staff that were unable to attend the live session.

A: We will post it in the same location where the slides are currently posted. The slide deck is available on CMS's webpage, https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/index.html. Following the presentation, we will attach a list of FAQ's to an updated version of the slide deck so that all can benefit from questions sent to the Call Center Monitoring mailbox after the call. This updated slide deck will also include clarifications to several questions asked during the webinar. We will post the recording with the updated slide deck.

I do want to point out that we had some audio difficulties in the beginning of the webinar, so the first 13 minutes of the original recording were not audible and were edited out of the recording. Therefore, I am sharing the script that accompanied the first 13 slides so that all can benefit from the section they may not have been able to hear.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Call Center Monitoring

February 3, 2016

1:00-3:00 pm ET

Presented by CMS Call Center Monitoring Team

SCAN-AR00329

Welcome!

A formal question and answer session will follow the presentation for study-related questions

Please send plan-specific questions to CallCenterMonitoring@cms.hhs.gov.

This presentation is being recorded. The slides and recording will be available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/index.html.

Please mute your phones and do not put the webinar on hold.

Introductions

CMS, Medicare Drug Benefit and C&D Data Group

Linda Anders, Acting Division Director, Division of Benefit Purchasing and Monitoring

Chris Rotruck – Project Lead for Call Center Monitoring/Contracting Officer's Representative (COR)

Gregory Bottiani – Prior Project Lead for Call Center Monitoring and Alternate COR

Monitoring Contractor: IMPAQ International, LLC

SCAN-AR00331

Agenda

- Introductions
- CMS Authority and Resources
- The Surveys: Timeliness/Accuracy & Accessibility
  - Automated Call Process
  - Summary and Call Data
  - Compliance
- Methodology
- Tips for Success
  - TTY
  - Limited English Proficiency
  - Accuracy Questions
- Star Ratings

Disclaimer

Nothing in this presentation is intended to supersede the regulations at 42 C.F.R. Part 422, 42 C.F.R. Part 423, the Prescription Drug Benefit Manual, the Medicare Managed Care Manual, or any other CMS guidance or instructions related to the operation of the MA program or Part D program. Failure to reference a regulatory requirement or CMS instruction in this presentation does not affect the applicability of such requirement.

Code of Federal Regulations (CFR) Authority

- 42 C.F.R. § 422.111(h)(1) - Each Medicare Advantage organization must have mechanisms for providing specific information on a timely basis to current and prospective enrollees upon request.
- 42 C.F.R. § 422.112(a)(8) – provide culturally competent care
- 42 C.F.R. § 423.128(d)(1) - provide foreign language interpreters
- 42 C.F.R. § 423.128(d)(1) – toll-free customer call center for beneficiaries and pharmacists. The regulations do not distinguish between hearing and non-hearing individuals; therefore, the regulations apply to all beneficiaries regardless of hearing status or language ability.
- Electronic Code of Federal Regulation http://www.eCFR.gov

Resources

- Marketing Guidelines
  - Medicare Marketing Guidelines (July 2, 2015), 30.5, 80.1, Appendix 3 http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html
- Documentation
  - Call Center Monitoring memo published in HPMS on December 22, 2015.

Which call centers are monitored?

CMS Monitors:

- All Medicare Advantage Organizations
- Prescription Drug Plan Sponsors
- Medicare/Medicaid Plans (MMPs)

Contracts Not Included in Call Center Monitoring:

- National PACE contracts
- Cost contracts (1876 Cost)
- Employer Group Waiver Plans (EGWPs) – 800 series
- Point of Sale Contractors
- Medicare Savings Accounts (MSAs)

Notes:

- Special Needs Plans are excluded from our Accuracy measure.
- Plans under Marketing and Enrollment Sanctions are excluded from the Accuracy & Accessibility Study until the sanctions are released.

Part C and Part D Required Hours of Operation

Plans/Part D Sponsors must operate **a toll-free** call center

- seven (7) days a week
- from at least 8:00 a.m. to 8:00 p.m. **according to the time zones for the regions in which they operate.**

Remember: From February 15 to September 30, Plans/Part D Sponsors may use alternative technologies on Saturdays, Sundays, and federal holidays.

- Medicare Marketing Guidelines, 80.1

Pharmacy Technical Help Desk Required Hours of Operation

Must be a **toll-free** number.

Must operate during “usual business hours.”

-Medicare Marketing Guidelines, Appendix 3

The Studies

- Timeliness Study
- Accuracy and Accessibility Study

Timeliness Study
When and What it Measures

- Conducted Quarterly
  - 4 weeks Enrollee (Parts C and D); 4 weeks Pharmacy
- Measures (performed by phone number)
  - Hold Times
  - Disconnect Rates
- Passing Scores
  - Average Hold Time of 2 minutes or less
  - Disconnect Rate of 5% or less
  - Adjusted for Margin of Error

Timeliness Study Scope and Results

- Scope
  - Part C Current Member Phone Lines
  - Part D Current Member Phone Lines
  - Pharmacy Technical Assistance Phone Lines
  - Weekly phone number updates are pulled from HPMS
  - Must be TOLL FREE numbers
- Results
  - Summary data posted quarterly on HPMS
  - Email with letter attachment (non-compliant)
  - Raw Call Data available by request
  - Does NOT count towards Star ratings
  - Are display measures

Timeliness Study
Sample Format Provided in Compliance Letter

- Analysis Summary Data

  - Appears on non-compliance communication
  - Posted to HPMS

Timeliness Study Results Posted to HPMS

To find your results in HPMS, follow these paths:

- For Part C results, from the HPMS home page (https://www.hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part C Beneficiary Customer Service > [select time period] > [enter the contract number]. **See column "G" for average hold time data and column "J" for disconnect rate data.**

- For Part D results, from the HPMS home page (https://www.hpms.cms.gov): > Quality and Performance > Performance Metrics and Reports > Call Center Monitoring > Part C Beneficiary Customer Service > [select time period] > [enter the contract number]. **See column "G" for average hold time data and column "J" for disconnect rate data.**

- For Pharmacy technical help desk results, from the HPMS home page (https://www.hpms.cms.gov): > Quality and Performance > Performance Metrics and Reports > Call Center Monitoring > Pharmacy Support Customer Service > [select time period] > [enter the contract number]. **See column "G" for average hold time data and column "J" for disconnect rate data. This is the average hold time.**

Timeliness Study
Call Center Performance Metrics

HPMS
Health Plan Management System

Health Plan Management System

Home

create PDF

Beneficiary Customer Service Call Center Performance Metrics

Z9999 Sample Health Plan

Call Center Performance Metric Comparison For Beneficiary Customer Service Centers

04/22/2013 TO 04/26/2013

	A	B	C	D	E	F	G	H	I	J	K	L
	Total Number of Monitoring Calls	Total Number of Successful Monitoring Calls	Total Number of Monitoring Calls with a 10 Minute Hold	Total Number of Unsuccessful Monitoring Calls	Percentage of Unanswered Calls[1]	Average Time Spent in IVR System (min:sec)	Average Hold Time (min:sec)[2]	Median Hold Time (min:sec)[2]	Average Time to Reach a Live Person (min:sec)	Percentage of Calls Disconnected (Benchmark <=5%)	Excluding Calls Abandoned due to a 10 Minute Hold: Average Hold Time (min:sec)[2]	Excluding Calls Abandoned due to a 10 Minute Hold: Median Hold Time (min:sec
Contractor Enrollee - Current Week	33	31	0	4	0.00%	0:28	0:01	0:00	0:29	2.86%	0:01	0:00
Contractor Enrollee - Current Quarter	140	121	0	19	0.00%	0:28	0:04	0:00	0:36	0.71%	0:04	0:00
Contractor Enrollee - Cumulative (Year-To-Date)	280	251	1	28	0.00%	0:33	0:10	0:00	0:39	1.07%	0:08	0:00

[1] - Excluding time spent navigating the IVR system, if applicable.
[2] - Unanswered calls include those that reached an answering machine/voice mail, had a busy signal, reached a fax/modem line, were out of service, or rang with no answer.

Z9999 Sample Health Plan

Unsuccessful Calls for Current Week (from column D above)

04/22/2013 TO 04/26/2013

Call Outcome Description	Beneficiary: Number of Unsuccessful Calls	Beneficiary: Percent of Unsuccessful Calls
Survey could not continue for other reasons	3	75.0%
Survey could not continue, Call Center disconnected call	1	25.0%
Total	**4**	**100.0%**

Technical Notes

Back

Go To: HPMS Home Page | Part C Performance Metrics Start Page | Select Contract Number Page

SCAN-AR00344

Timeliness Study
Summary Data Fields – Part 1

- Total Number of Calls
- Total Number Successful Calls
- Total Calls with a 10 minute Hold
- Total Unsuccessful Calls
- % of Calls Unanswered
- Average Time in IVR
- **Average Hold Time**

SCAN-AR00345

Timeliness Study
Summary Data Fields – Part 2

- Median Hold Time
- Average Time to Live CSR
- **Disconnected Call Percentage**
- Average and Median Hold Time Without 10 Minute Hold

Timeliness Study
Unsuccessful Calls

- Unsuccessful Calls Include:
  - Breakdown By Reason
  - Count
  - Percent
- Technical Notes contain definitions.
  - Access from bottom of HPMS screen.
  - Updated version coming soon.

Timeliness Study
Percentage of Calls Disconnected

From 2016 Call Center Monitoring Memo

The percent of disconnected calls is defined as the number of calls unexpectedly dropped by the sponsor while the caller was navigating the IVR or connected with a Customer Service Representative divided by the total number of calls made to the phone number associated with the contract.

Organization Type	Contract Type (0=RA-PD, 1=POP)	Week Date	Call Week	Study Type (R=Rheumatoid, P=pharma)	Data Type	Total Number of Monitoring Calls	Total Number of Successful Monitoring Calls (CAS_CaseStatus =295)	Total Number of Monitoring Calls with a 30 minute Hold (CAS_CaseStatus =292)	Total Number of Unsuccessful Monitoring Calls	Percentage of Unsuccessful Calls (CAS_CaseStatus =291)	Average Time Spent in IVR System (minsec)	Average Hold Time (minsec)	Met / Not Met Average Hold Time of 2 Minutes or Less (Met=1, Not Met=0)	Percentage of Calls with Hold Time of 30 Seconds or Less (Benchmark >=80%)	Median Hold Time (minsec)	Average Time to Reach a Live Person (Time Spent in IVR + Hold Time (minsec))	Percentage of Calls Disconnected (Benchmark <=5%) (CAS_CaseStatus =293.5)	Met / Not Met Disconnection Performance Standard of 5% of Calls (Met=1, Not Met=0)	Average Hold Time (minsec)	Median Hold Time (minsec)	Percentage of Calls with Hold Time of 30 Seconds or Less (Benchmark >=80%)
Local CCP	0	06/28/201	26 6		WEEK	22	21	0	1	0.00%	1:51	0:08	1	85.71%	0:01	1:59	3.03%	1	0:08	0:01	85.71%
Local CCP	0	06/28/201	26 6		QUARTER	93	91	0	1	0.00%	1:49	0:04	1	93.41%	0:01	1:54	1.08%	1	0:04	0:01	93.41%
Local CCP	0	06/28/201	26 6		CUMULAT	204	196	0	10	0.00%	1:44	0:03	1	95.90%	0:01	1:48	1.95%	1	0:03	0:01	95.90%

The numerator is the total number of disconnected calls (codes 293.5, 296.01, 296.05).
Remember: All codes are defined in the data dictionary delivered with any raw data request.

The denominator is the total number of monitoring calls found in the raw data file.

With one (1) disconnected call in this quarter, and 93 total calls in the quarter, the formula is 1/93 *100, for a disconnect rate of 1.0752%, or rounded up to 1.08% (quarterly). In this example, there were 4 disconnected calls cumulatively, so 4/204*100 = 1.96% (cumulatively).

Pharmacy Technical Assistance
Example: 1-800-111-2222

	Contract H111A	Contract H222B	Contract S111C	Contract H111D
Plan 001	Eastern Calls placed 8 am-midnight EST	Eastern Calls placed 8 am-midnight EST	Mountain Calls placed 10 am to 10 pm EST	Eastern Calls placed 8 am-midnight EST
Plan 002	Central Calls placed 9am-1:00 am EST	Alaska Calls placed 12 noon to 4 am EST	Hawaii Calls placed 1:00 pm. to 5 am EST	Eastern Calls placed 8 am-midnight EST
Original Method	All calls for this contract through midnight local time (1:00 am EST)	All calls for this contract through midnight local time (4:00 a.m. EST)	All calls for this contract through midnight local time (5:00 a.m. EST)	All calls for this contract through midnight local time (midnight EST)
Revised Method	All calls to this phone number based on 24-hour operation	All calls to this phone number based on 24-hour operation	All calls to this phone number based on 24-hour operation	All calls to this phone number based on 24-hour operation

Raw Data Requests

Email CallCenterMonitoring@cms.hhs.gov

Include detailed information in your request:

- contract ID
- Identify the information you are requesting (e.g., Timeliness Study for Quarter 1 of 2016)

It may take up to two weeks to fulfill your request for raw data. Thank you for your patience.

SCAN-AR00350

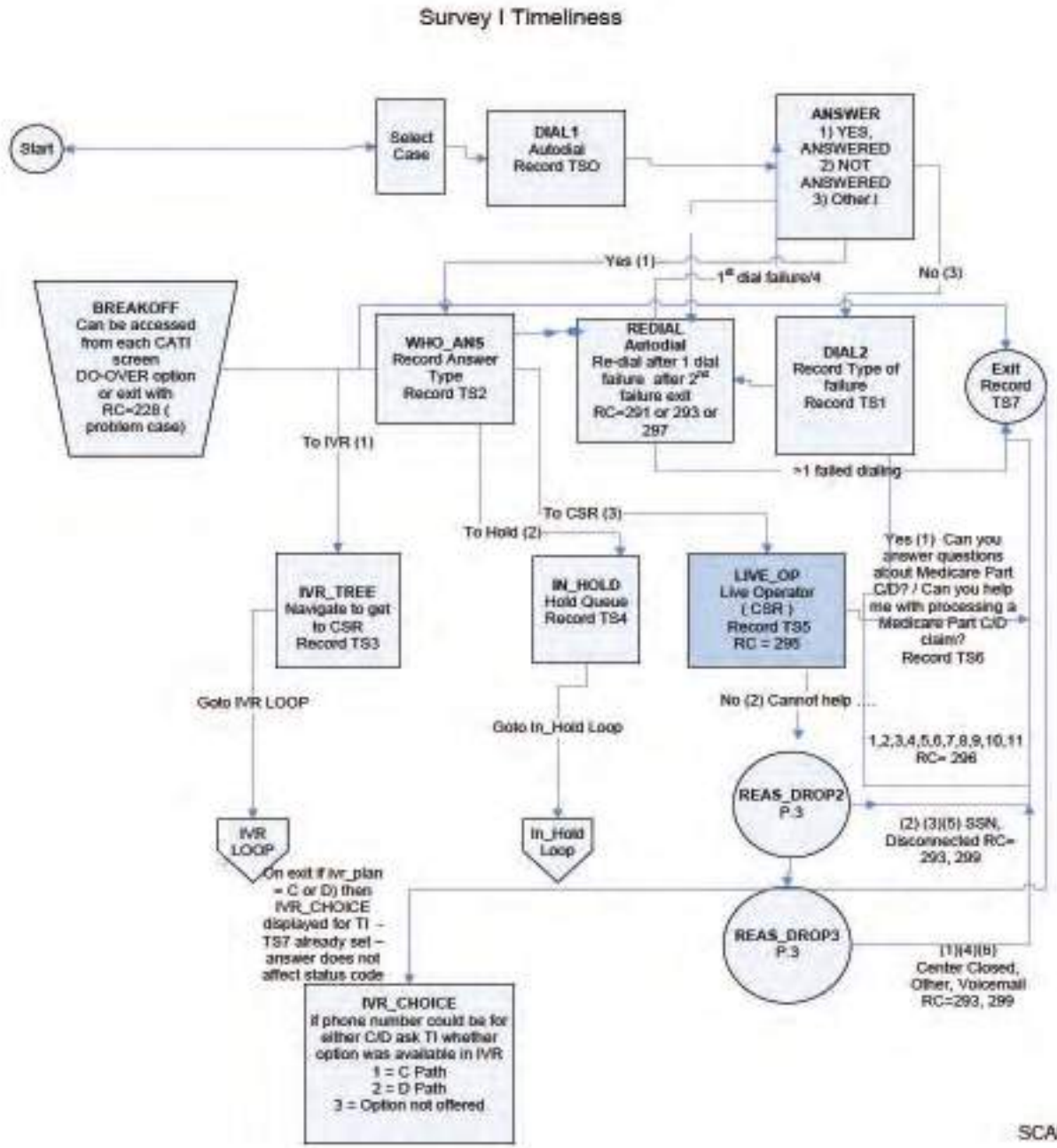
Automated Call Pre-Process

- Computer Assisted Telephone Interview (CATI) System
  - Pre-process
    - Determine phone numbers to call
    - Determine number of calls based on statistical models
    - Load to CATI
    - CATI schedules calls

Automated Survey Call Process

- Computer Assisted Telephone Interview (CATI) System
  - Survey Begins
    - System uses an auto-dialer.
    - CATI prompts telephone interviewer
    - At each stage of the call telephone interviewer records milestones
    - CATI timestamps each milestone
    - Each call may be dialed twice before moving to next call
    - In-progress call may be redialed by interviewer in case of error (example: selected wrong IVR option)

Timeliness Study – Five Stages of Data Capture



IVR Loop and HOLD Loop not shown

SCAN-AR00353

Timeliness Study
Raw Call Data Fields

- Raw Call Data Fields
  - Date and Time Stamps
    - TS0 … Start Time of dial
    - TS1 … Phone answer failure time
    - TS2 … Phone answer success time
    - TS3 … Start of IVR time
    - TS4 … Start of Hold Time
    - TS5 … Time of answer by CSR
    - TS6 … Time when call was disconnected
    - TS7 … Time when interviewer exited the case

Key Data Fields

- Raw Call Data Fields
  - Case Id … Identifier
  - Call Status … Final disposition of the call
  - Phone number dialed
  - Date and Time Stamps

Raw data is accompanied by a data dictionary to help you interpret the information.

Compliance

Compliance action taken depends on

- Compliance history
- Severity

General Compliance Spectrum

- Notice of Non-compliance
- Warning Letter
- Warning Letter with Request for Business Plan
- Corrective Action Plan

Compliance Spectrum Timeliness Study

- Conducted once each quarter.
- Compliance actions “build” each quarter.
- If non-compliant in all four quarters of any year, one would reach a CAP by quarter 4.

NONC → WL → WL w Bus Plan → CAP

SCAN-AR00358

Compliance Spectrum Timeliness Study (continued)

CMS reserves the right to “reset” the compliance spectrum with the start of each new year for the Timeliness Study.

We expect every contract to have a “clean slate” as we begin 2016, assuming no egregious issues are identified from late 2015.

Methodologies

- Timeliness Survey
  - Measured at the **Phone Number level**
  - Stratified Split Sample
- Accuracy and Accessibility Survey
  - Measured at the **Call Center Level**
  - Simple Random Sample

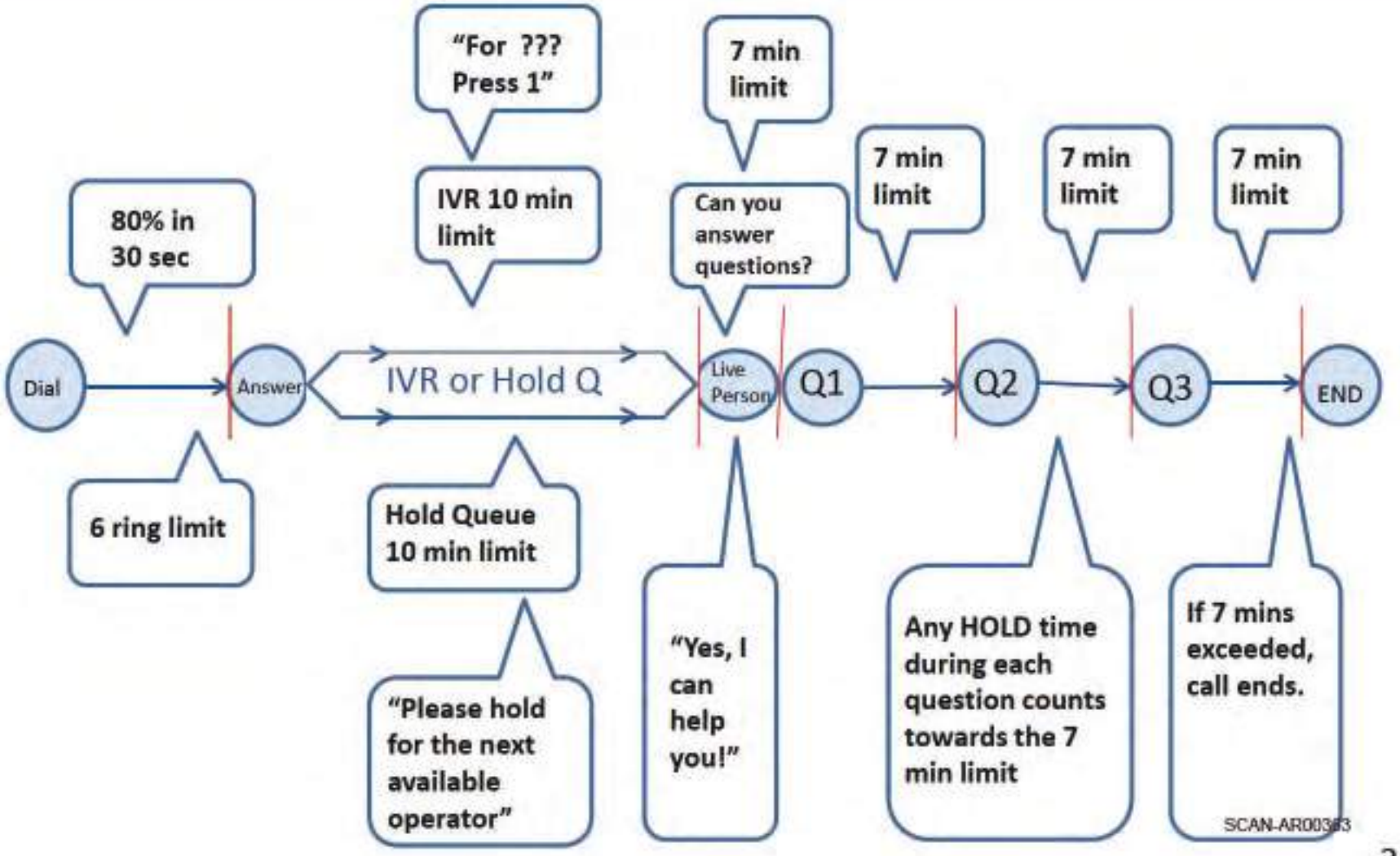
Accuracy and Accessibility Study

- Annual (February through May)
- Measures
  - Interpreter Availability
  - TTY Availability
  - Information Accuracy
- Passing Scores
  - Interpreter 75%
  - TTY 60%
  - Accuracy 75%
  - Adjusted for Margin of Error

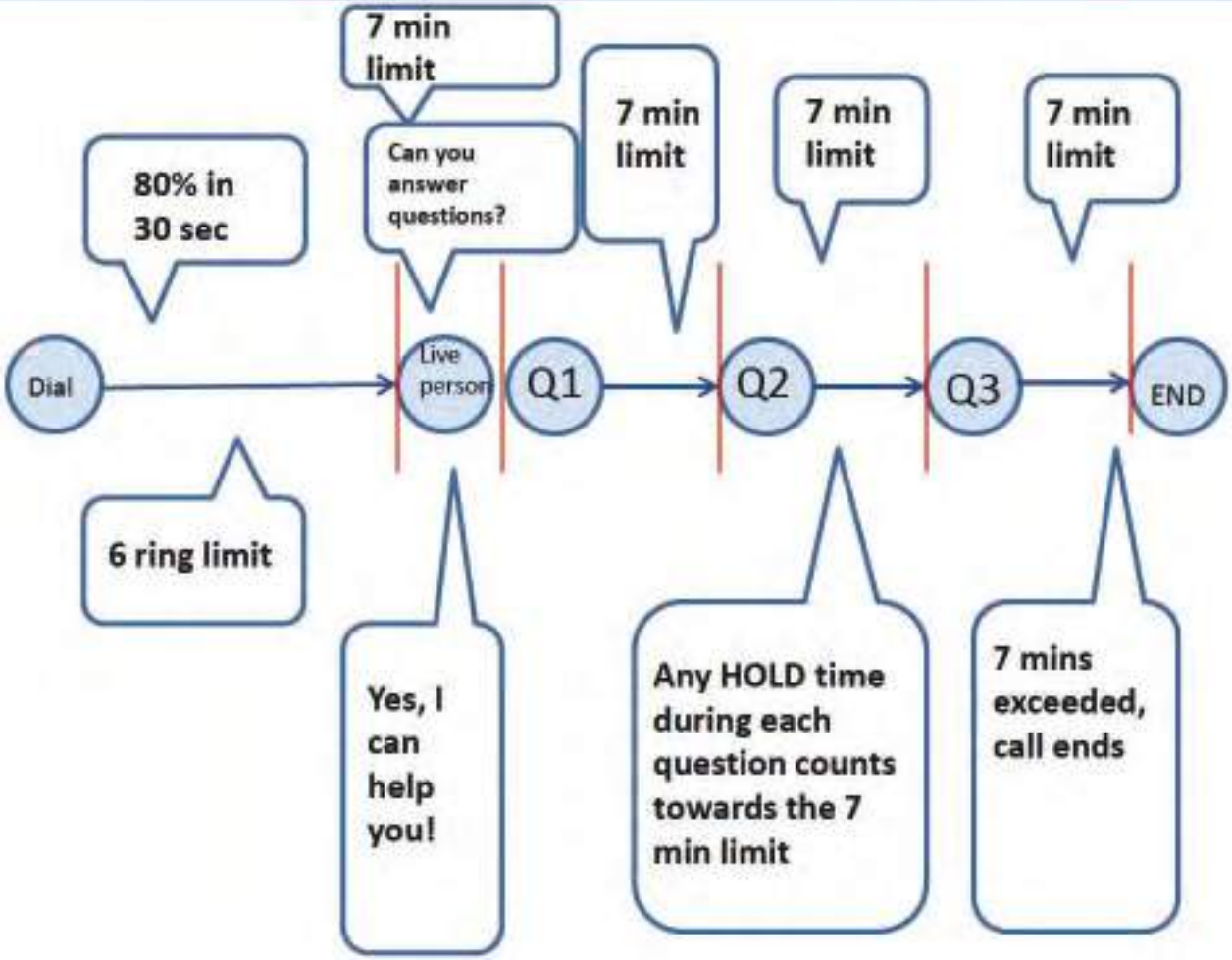
Accuracy and Accessibility Study Scope

- Scope
  - Part C Prospective Member Number
  - Part D Prospective Member Number
  - TTY Prospective Member Number
  - Biweekly phone number updates
  - Must be a TOLL FREE number
  - Interpreters for 2016
    - English
    - Spanish
    - Mandarin
    - Cantonese
    - French
    - Tagalog
    - Vietnamese
  - Puerto Rico: Spanish is primary. English and others are secondary

Timers: Hold/IVR



Timers: Live CSR



SCAN-AR00364

Star Rating

- Two values from Accuracy and Accessibility study
  - Interpreter Availability
  - TTY Availability
- Two measures for Call Center Foreign Language Interpreter and TTY Availability
  - C32
  - D01

Star Ratings
Technical Notes Preview

The calculation of this measure is the number of successful contacts with the interpreter and TTY divided by the number of attempted contacts. Successful contact with an interpreter is defined as establishing contact with an interpreter and beginning the first of three survey questions. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language (Spanish in Puerto Rico and English elsewhere) about the plan sponsor's Medicare benefits. Successful contact with a TTY service is defined as establishing contact with and confirming that the TTY operator can answer questions about the plan's Medicare Part C (or Part D) benefit.

Star Rating - Formula

- Calculation

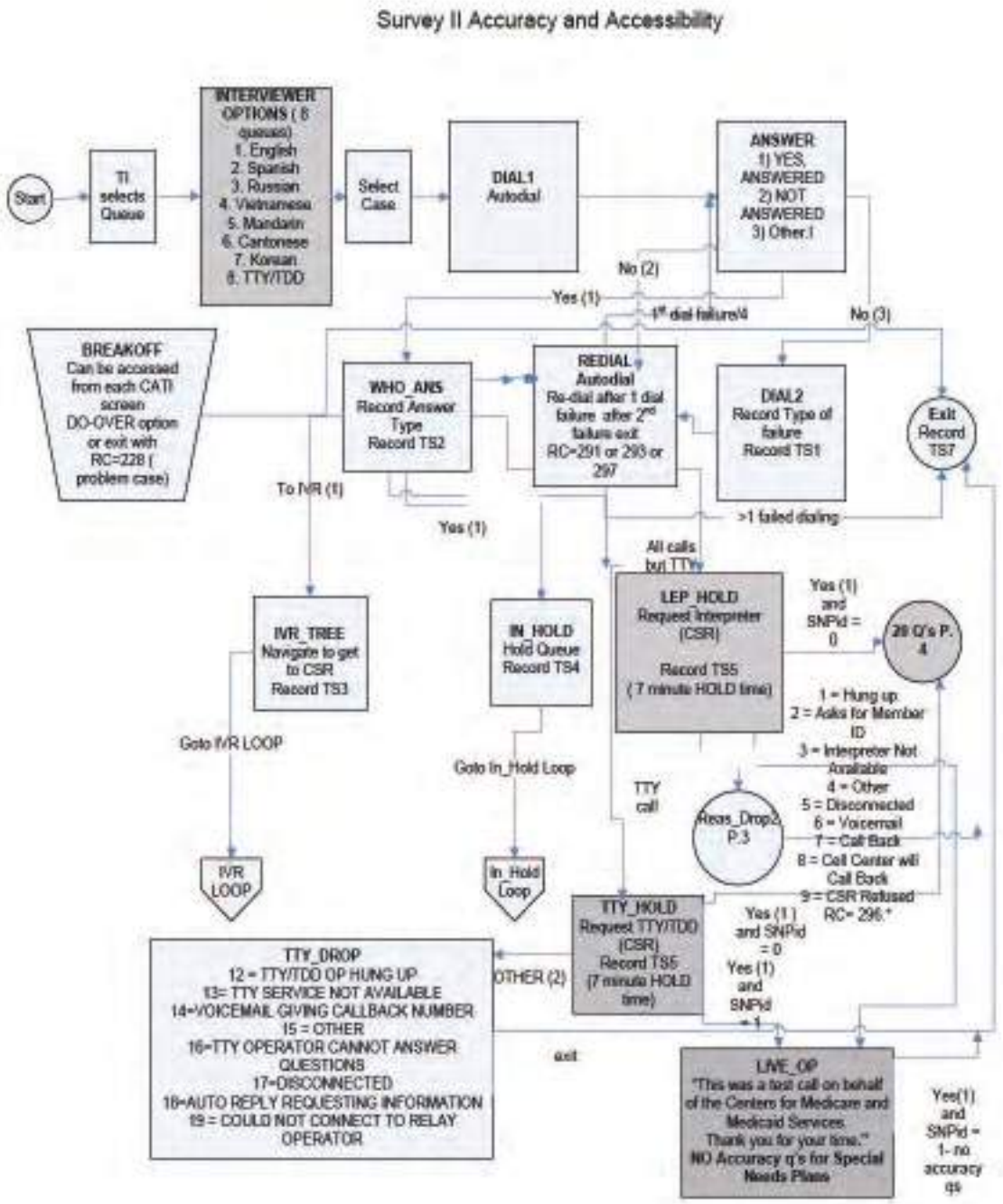
$$\frac{\text{\# Successful TTY calls + \# Completed LEP calls}}{\text{\# TTY calls + \# LEP calls}}$$

- More info on Star Ratings

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html

  - CMS PartDMetrics PartDMetrics@CMS.hhs.gov
  - CMS Part C Ratings PartCRatings@cms.hhs.gov

Accuracy and Accessibility Automated Call Process



IVR Loop and HOLD Loop not shown

SCAN-AR00368

Accuracy and Accessibility Results

- Results
  - Summary data posted to HPMS
  - Email with letter attachment
    - All monitored contracts
    - Areas of non-compliance are noted
    - Data used to calculate Star rating measures are included
  - Raw Call Data available by request at CallCenterMonitoring@cms.hhs.gov

Accuracy and Accessibility Results Posted to HPMS

- Detailed results will be available in the HPMS at the following paths:

- For Part C results, from the HPMS home page (https://www.hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part C Prospective Beneficiary Customer Service > [enter the contract number].

- For Part D results, from the HPMS home page (https://www.hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part D Prospective Beneficiary Customer Service > [enter the contract number].

Analysis Summary – Part 1

HPMS
Health Plan Management System

Health Plan Management System
Home

create PDF

Prospective Beneficiary Customer Service Call Center Performance Metrics

Z9999 Sample Health Plan

Call Center Performance Metric Comparison For Prospective Beneficiary Customer Service Centers

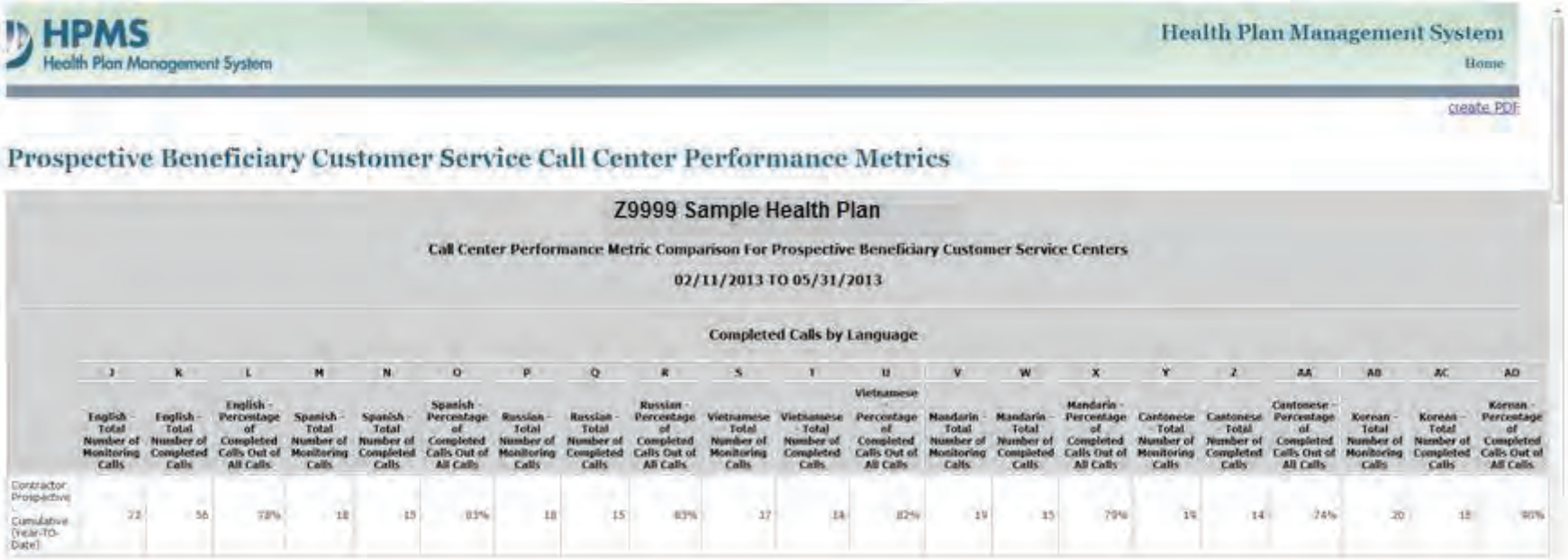
02/11/2013 TO 05/31/2013

Summary Data on Monitoring Calls

	A	B	C	D	E	F	G	H	I
	All Calls - Total Number of Monitoring Calls	All Calls - Total Number of Completed Monitoring Calls	All Calls - Percentage of Completed Calls Out of All Calls	Total Number of LEP Monitoring Calls	Total Number of Completed LEP Monitoring Calls Out of All LEP Calls	Percentage of Completed Calls Out of All LEP Calls	Total Number of TTY Monitoring Calls	Total Number of Successful calls to the organization TTY/TDD number	Percentage of Successful calls to organization TTY/T number
Contractor Prospective - Cumulative (Year-TO-Date)	215	173	80%	111	91	82%	32	26	8

SCAN-AR00371

Analysis Summary – Part 2



HPMS
Health Plan Management System

Health Plan Management System
Home

create PDF

Prospective Beneficiary Customer Service Call Center Performance Metrics

Z9999 Sample Health Plan

Call Center Performance Metric Comparison For Prospective Beneficiary Customer Service Centers

02/11/2013 TO 05/31/2013

Completed Calls by Language

	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD
	English - Total Number of Monitoring Calls	English - Total Number of Completed Calls	English - Percentage of Completed Calls Out of All Calls	Spanish - Total Number of Monitoring Calls	Spanish - Total Number of Completed Calls	Spanish - Percentage of Completed Calls Out of All Calls	Russian - Total Number of Monitoring Calls	Russian - Total Number of Completed Calls	Russian - Percentage of Completed Calls Out of All Calls	Vietnamese - Total Number of Monitoring Calls	Vietnamese - Total Number of Completed Calls	Vietnamese - Percentage of Completed Calls Out of All Calls	Mandarin - Total Number of Monitoring Calls	Mandarin - Total Number of Completed Calls	Mandarin - Percentage of Completed Calls Out of All Calls	Cantonese - Total Number of Monitoring Calls	Cantonese - Total Number of Completed Calls	Cantonese - Percentage of Completed Calls Out of All Calls	Korean - Total Number of Monitoring Calls	Korean - Total Number of Completed Calls	Korean - Percentage of Completed Calls Out of All Calls
Contractor Prospective - Cumulative (Year-TO-Date)	72	56	78%	18	15	83%	18	15	83%	17	14	82%	19	15	79%	19	14	74%	20	18	90%

SCAN-AR00372

Analysis Summary – Part 3

HPMS
Health Plan Management System

Health Plan Management System

create PDF

Prospective Beneficiary Customer Service Call Center Performance Metrics

Z9999 Sample Health Plan

Call Center Performance Metric Comparison For Prospective Beneficiary Customer Service Centers

02/11/2013 TO 05/31/2013

Summary Data on Accuracy

	AE All Calls - Total Number of Medicare Questions Asked	AF All Calls - Total Number of Accurate Answers to all Medicare Questions	AG All Calls - Percentage of Accurate Answers to all Medicare Questions
Contractor Prospective - Cumulative (Year-TO-Date)	230	144	78%

Z9999 Sample Health Plan

Call Center Performance Metric Comparison For Prospective Beneficiary Customer Service Cente

02/11/2013 TO 05/31/2013

Accuracy Results by Question

	AH Question 1 - Total Number of Questions Asked	AI Question 1 - Total Number of Accurate Answers	AJ Question 2 - Total Number of Questions Asked	AK Question 2 - Total Number of Accurate Answers	AL Question 3 - Total Number of Questions Asked	AM Question 3 - Total Number of Accurate Answers	AN Question 4 - Total Number of Questions Asked	AO Question 4 - Total Number of Accurate Answers	AP Question 5 - Total Number of Questions Asked	AQ Question 5 - Total Number of Accurate Answers	AR Question 6 - Total Number of Questions Asked	AS Question 6 - Total Number of Accurate Answers	AT Question 7 - Total Number of Questions Asked	AU Question 7 - Total Number of Accurate Answers	AV Question 8 - Total Number of Questions Asked	AW Question 8 - Total Number of Accurate Answers	AX Question 9 - Total Number of Questions Asked	AY Question 9 - Total Number of Accurate Answers	AZ Question 10 - Total Number of Questions Asked	BA Question 10 - Total Number of Accurate Answers	BB Question 11 - Total Number of Questions Asked	BC Question 11 - Total Number of Accurate Answers	BD Question 12 - Total Number of Questions Asked	BE Question 12 - Total Number of Accurate Answers	BF Question 13 - Total Number of Questions Asked
Contractor Prospective - Cumulative (Year-TO-Date)	10	9	10	13	9	9	13	13	11	10	16	13	14	11	9	2	9	9	7	9	12	12	14	11	17		

SCAN-AR00373

Analysis Summary – Part 4

HPMS
Health Plan Management System

Health Plan Management System
Home

create PDF

Prospective Beneficiary Customer Service Call Center Performance Metrics

	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW	AX	
	Question 1- Total Number of Questions Asked	Question 1- Total Number of Accurate Answers	Question 2- Total Number of Questions Asked	Question 2- Total Number of Accurate Answers	Question 3- Total Number of Questions Asked	Question 3- Total Number of Accurate Answers	Question 4- Total Number of Questions Asked	Question 4- Total Number of Accurate Answers	Question 5- Total Number of Questions Asked	Question 5- Total Number of Accurate Answers	Question 6- Total Number of Questions Asked	Question 6- Total Number of Accurate Answers	Question 7- Total Number of Questions Asked	Question 7- Total Number of Accurate Answers	Question 8- Total Number of Questions Asked	Question 8- Total Number of Accurate Answers	Question 9- Total Number of Questions Asked	Q 9 N Ac Ar
Contractor Prospective - Cumulative (Year-TO-Date)	10	8	18	13	9	6	13	13	11	10	16	15	16	15	6	2	9	

Back | Download to Excel

SCAN-AR00374

Analysis Summary – Part 5

HPMS
Health Plan Management System

Health Plan Management System

Prospective Beneficiary Customer Service Call Center Performance Metrics

Z9999 Sample Health Plan

02/11/2013 TO 05/31/2013

Accuracy Results by Question

AY	AZ	BA	BB	BC	BD	BE	BF	BG	BH	BI	BJ	BK	BL	BM	BN	BO	BP
Question 9- Total Number of Accurate Answers	Question 10- Total Number of Questions Asked	Question 10- Total Number of Accurate Answers	Question 11- Total Number of Questions Asked	Question 11- Total Number of Accurate Answers	Question 12- Total Number of Questions Asked	Question 12- Total Number of Accurate Answers	Question 13- Total Number of Questions Asked	Question 13- Total Number of Accurate Answers	Question 14- Total Number of Questions Asked	Question 14- Total Number of Accurate Answers	Question 15- Total Number of Questions Asked	Question 15- Total Number of Accurate Answers	Question 16- Total Number of Questions Asked	Question 16- Total Number of Accurate Answers	Question 17- Total Number of Questions Asked	Question 17- Total Number of Accurate Answers	Question 18- Total Number of Questions Asked
6	7	6	12	12	13	11	17	8	16	6	11	11	15	11	12	11	10

SCAN-AR00375

Analysis Summary – Part 6

HPMS
Health Plan Management System

Health Plan Management System

Prospective Beneficiary Customer Service Call Center Performance Metrics

BQ	BR	BS	BT	BU
Question 18- Total Number of Accurate Answers	Question 19- Total Number of Questions Asked	Question 19- Total Number of Accurate Answers	Question 20- Total Number of Questions Asked	Question 20- Total Number of Accurate Answers
1	13	13	16	16

SCAN-AR00376

Raw Call Data - Data Elements

- Contract ID
- Call Center Indicator
- Disposition Status
- Phone Number Called
- Survey Type
- IVR Disposition
- IVR keypress1 through IVR keypress9

Raw Call Data – Data Elements Part 2

- TS0-Start of Dial
- TS1-Answer Failure Time
- TS2-Answer Success Time
- TS3-Start of IVR Time
- TS4-Start of Hold Time
- TS5-CSR Answered
- TS6-Disconnected OR Start of Accuracy Questions

Raw Call Data – Data Elements Part 3

- TS601-Exit from Question 1, reset timer
- TS602-Exit from Question 2, reset timer
- TS603-Exit from Question 3
- TS7-Call End Time
- Call Duration in Seconds
- Hold Time in Seconds
- IVR Time in Seconds

Raw Call Data – Data Elements Part 4

- Language
- Contract ID
- Plan ID
- Plan Name
- Language Interpreter Hold Time in Seconds
- Call Time in Minutes
- Call Center Indicator

Raw Call Data – Data Elements Part 5

- Additional fields available for advanced troubleshooting
  - Telephone Interviewer comments
  - Accuracy question data

Compliance – Accuracy & Accessibility

Compliance Spectrum by Year

- TTY – 2015
- Interpreter Availability - 2015
- Accuracy - 2016

Compliance Reminder

Compliance actions may also be taken in other areas where an organization is either an outlier with respect to other sponsors or so far below CMS' reasonable expectations that notice is warranted in order to ensure that the organization provides current enrollees with the services to which they are entitled. These areas include, but are not limited to, **inappropriate call center closures (i.e., closed during business hours) and failure to maintain a toll-free telephone number for that organization's enrollees.**

TIPS - Telecommunications Relay Services (TRS)

- Umbrella of services for hearing and speech impaired persons
- Available in all 50 states, the District of Columbia, Puerto Rico and the U.S. territories for local and/or long distance calls.
- TTY is just one of the TRS services
- FCC web site has information on TRS
- http://www.fcc.gov/guides/telecommunications-relay-service-trs

TIPS - Text to Voice (TTY) - Part 1

- History – from teletypewriters to digital devices
- Hearing/Speech impaired use their TTY to reach the relay service
- Relay operator calls the requested number and relays the message or question
- Relay operator then relays the reply to the caller

TIPS - Text to Voice (TTY) – Part 2

- 711 number established
- Similar to 911 – no 10 digit number to memorize
- FCC list for each state

http://www.fcc.gov/encyclopedia/telecommunications-relay-services-directory

TIPS - Text to Voice (TTY) – Part 3

Maryland

TRS Provider - Hamilton Relay; Captioned Telephone (CapTel): Hamilton Relay
Address: P.O. Box 285, Aurora, NE 68818
Customer Service #'s: 1-800-552-7724(V/T)
Email: mdrelay@hamiltonrelay.com

Access #'s:
711 - In Maryland
1-800-201-7165(V/T)
1-800-735-2258(TTY/HCO)
1-888-826-9673(VCO)
1-800-785-5630(STS)
1-877-735-5151(ASCII)
1-877-258-9854(2-Line VCO)
1-855-828-6465 (VA STS)
1-800-877-1264(Spanish)

TIPS - Text to Voice (TTY) – Part 4

- Test TTY calls using the local relay in your plan's service area.
- FCC website maintains a list of toll-free numbers for each relay.
- If you have difficulty connecting to the relay number, consult your phone company.

TIPS – TTY Functionality

- If using an in-house TTY device, regularly test your device to ensure that it is working properly.
- If using an in-house TTY device, have a staffing plan that includes coverage for the TTY device during the hours your call center is required to operate with live CSRs.
- Messages that ask a caller to leave their phone number are not appropriate, and will not be counted as a successful call. Callers need to be able to communicate with a live person when they call.
- Ensure that wait times for a CSR or state relay operator are not lengthy.
- Ensure that CSRs are available within 7 minutes of the time of answer. CMS considers a CSR unavailable if the caller or relay operator is unable to communicate with the CSR.
- Ensure that CSRs or state relay operators are able to respond promptly to questions. By protocol, each question has a 7-minute timer.

TIPS - Language Interpretation Services – Part 1

- Do you have CLAS?
- *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care*
- https://www.thinkculturalhealth.hhs.gov/
- Contact AdvancingCLAS@ThinkCulturalHealth.hhs.gov

TIPS - Language Interpretation Services – Part 2

- Utilize an interpretation service to identify the beneficiary's language.
- **Use interpretative services personnel who are familiar with healthcare terms and Medicare benefit concepts**.
- Train CSRs to connect foreign-language callers with an interpreter.
- Ensure CSRs stay on the phone when a foreign-language interpreter joins the call.
- In order to replicate a beneficiary's actual experience, CMS telephone interviewers who are testing a language other than English will not make a selection in the IVR based upon the premise that a non-English-speaking person would not understand the instruction. Therefore, **ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu.**
- Include a note on the beneficiary's call center record that indicates his/her preferred language, if other than English.

TIPS - Language Interpretation Services – Part 3

- Maintain and use a tracking system so that once a beneficiary's language is identified, it is recorded and used for future contacts (both oral and written).
- Monitor CSR calls to ensure that foreign-language calls are being handled according to the sponsor's policies and procedures.
- Remind CSRs that CMS' study is underway February through May, and inform new staff of CMS' study so they are not surprised by foreign-language callers.
- Ensure that interpreters are available within 7 minutes of the caller reaching a CSR.
- Ensure that CSRs are able to respond promptly to questions. By protocol, each question has a 7-minute timer.
- Consult CLAS Blueprint on the Cultural Health web site.

TIPS - Accuracy Questions – Part 1

- Questions for 2016 are not released until the end of the study
- Some questions are renewed from year to year
- Some new questions are added
- Approximately 18-20 questions each for Part C and Part D

TIPS - Accuracy Questions – Part 2

- Ensure that CSRs can respond to questions regarding items listed in the Medicare Marketing Guidelines, Section 80.1.
- Review the 2016 edition of *Medicare & You* to ensure your CSRs are trained on new Part C and Part D benefit information for 2016.
- CSRs should have specific plan benefit package (PBP) level benefit and formulary data easily available.

TIPS - Accuracy Questions – Part 3

- Other resources
  - Landscape files
    - http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/
  - Part D Information , including Call Letters
    - http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/index.html
  - Regulations
  - PBP
  - Formulary
  - Managed Care Manuals
    - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=2&DLSort=0&DLSortDir=ascending

Communication

- Do not use secure email services to contact CMS.
- We do not have the resources to maintain user-ids and passwords.
- If you have concerns, contact us at

CallCenterMonitoring@cms.hhs.gov

Call Screening

- Survey calls may be easy to recognize, although we have de-identified/masked the number.
- Please tell your CSRs not to ask “Is this a test call?” or “Didn’t you call me yesterday?” Remember, your caller may not be our monitoring contractor: Be Professional!

Inclement Weather

Reminder: From February 15 to September 30, Plans/Part D Sponsors may use alternative technologies on Saturdays, Sundays, and Federal holidays.

Otherwise, your call centers must be open during required hours of operation. Be prepared with a back-up plan in case of inclement weather.

SCAN-AR00398

Emergencies

We remind Part D sponsors that they must continuously monitor both the Federal Emergency Management Agency (FEMA) Web site (http://www.fema.gov/) and the DHHS Web site (http://www.dhhs.gov/) for updates, changes and/or closures of existing emergency declarations.

SCAN-AR00399

The Bottom Line

- Hearing and Speech Impaired and Limited English Proficient Enrollees and Prospective Beneficiaries are some of the most vulnerable groups in our society.
- Successful results ensure they are getting the service they deserve.
- WIN-WIN-WIN for
  - Health Plan sponsors/**BENEFICIARIES**/CMS

Questions?

Open the phone lines!

How May I Serve You?

Email us at CallCenterMonitoring@cms.hhs.gov

Raw Data Requests

Answer your questions

Help you find resources (Technical Notes, Performance Metrics, HPMS Help Desk, etc.)

Call Center Monitoring

Thank you for attending our webinar.

Send Questions or Comments to

CallCenterMonitoring@cms.hhs.gov

Attachment A

Request for Reconsideration

Note: The QBP administrative review process is a two-step process that includes: 1) a request for reconsideration, and 2) a request for an informal hearing after CMS has rendered its reconsideration decision. Both steps are conducted at the contract level. This first step affords an MA organization the opportunity to request a reconsideration of how its Star Rating, for the given measure in question, was calculated. This is not an opportunity for an MA organization to question how every measure was calculated. A request for reconsideration must be submitted by the date and time specified below in order to reserve the right to later request an informal hearing on the record.

Instructions: Use only the "Request for Reconsideration" form that can be found in HPMS. To download a copy of the form from HPMS, select Quality and Performance on the home page, then Performance Metrics. On the Performance Metrics page select Reports, Costs and then MA QBP Rating. One form must be submitted for each contract for which reconsideration is requested. Complete the identifiable information including all contact information**.** Mark an "X" next to the measure(s) that the MA organization is questioning and requesting reconsideration. In the "Description of the Issue" specify any errors that the MA organization asserts CMS may have made in calculating the contract's QBP determination. Save the information, please include your contract number in the filename and e-mail the completed form along with any additional documentary evidence to be considered to QBPAPPEALS@cms.hhs.gov by the due date.

Due Date: A Request for Reconsideration of QBP is made by completing the Excel version of this form downloaded from HPMS and e-mailing the form to QBPAPPEALS@cms.hhs.gov by 5:00 p.m. EST on November 17, 2023. No late requests will be accepted.

Contract Number (5 character CMS assigned code):	H5425
Contact First Name (your first name):	Michael
Contact Last Name (your last name):	Plumb
Contact Title (your job title):	Chief Financial Officer
Contact Phone Number (your phone number, include extension if necessary):	714-655-9202
Contact email address (your email address):	mplumb@scanhealthplan.com

Overall Rating	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
QBP/Overall Rating	Star Ratings		Not Appealable	

Part C Measures	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
C01-Breast Cancer Screening	HEDIS		Not Appealable	
C02-Colorectal Cancer Screening	HEDIS		Not Appealable	
C03-Annual Flu Vaccine	CAHPS		Not Appealable	
C04-Monitoring Physical Activity	HEDIS / HOS		Not Appealable	
C05-Special Needs Plan (SNP) Care Management	Part C Plan Reporting		Not Appealable	
C06-Care for Older Adults – Medication Review	HEDIS		Not Appealable	
C07-Care for Older Adults – Pain Assessment	HEDIS		Not Appealable	
C08-Osteoporosis Management in Women who had a Fracture	HEDIS		Not Appealable	
C09-Diabetes Care – Eye Exam	HEDIS		Not Appealable	
C10-Diabetes Care – Blood Sugar Controlled	HEDIS		Not Appealable	
C11-Controlling Blood Pressure	HEDIS		Not Appealable	
C12-Reducing the Risk of Falling	HEDIS / HOS		Not Appealable	
C13-Improving Bladder Control	HEDIS / HOS		Not Appealable	
C14-Medication Reconciliation Post-Discharge	HEDIS		Not Appealable	
C15-Plan All-Cause Readmissions	HEDIS		Not Appealable	
C16-Statin Therapy for Patients with Cardiovascular Disease	HEDIS		Not Appealable	
C17-Transitions of Care	HEDIS		Not Appealable	
C18-Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS		Not Appealable	
C19-Getting Needed Care	CAHPS		Not Appealable	
C20-Getting Appointments and Care Quickly	CAHPS		Not Appealable	
C21-Customer Service	CAHPS		Not Appealable	
C22-Rating of Health Care Quality	CAHPS		Not Appealable	
C23-Rating of Health Plan	CAHPS		Not Appealable	
C24-Care Coordination	CAHPS		Not Appealable	
C25-Complaints about the Health Plan	CTM		Not Appealable	
C26-Members Choosing to Leave the Plan	MBDSS		Not Appealable	
C27-Health Plan Quality Improvement	Star Ratings		Not Appealable	
C28-Plan Makes Timely Decisions about Appeals	IRE			
C29-Reviewing Appeals Decisions	IRE			

C30-Call Center – Foreign Language Interpreter and TTY Availability	Call Center		X	We beleive incorrect data was used in the calculation for this measure given that one of the foreign language interpreter availability calls (C0600900) is incorrectly included in our results based on a technical issue associated with the non-standard manner in which the CMS caller asked the standard question. Please see the additional comments section below for the explanation.

Part D Measures	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
D01-Call Center – Foreign Language Interpreter and TTY Availability	Call Center			
D02-Complaints about the Drug Plan	CTM	Not Applicable	Not Applicable	Not appealable, use Part C measure C26 above.
D03-Members Choosing to Leave the Plan	MBDSS	Not Applicable	Not Applicable	Not appealable, use Part C measure C26 above.
D04-Drug Plan Quality Improvement	Star Ratings		Not Appealable	
D05-Rating of Drug Plan	CAHPS		Not Appealable	
D06-Getting Needed Prescription Drugs	CAHPS		Not Appealable	
D07-MPF Price Accuracy	PDE, MPF Pricing		Not Appealable	
D08-Medication Adherence for Diabetes Medications	PDE		Not Appealable	
D09-Medication Adherence for Hypertension (RAS antagonists)	PDE		Not Appealable	
D10-Medication Adherence for Cholesterol (Statins)	PDE		Not Appealable	
D11-MTM Program Completion Rate for CMR	Part D Plan Reporting		Not Appealable	
D12-Statin Use in Persons with Diabetes (SUPD)	PDE data		Not Appealable	

Additional Comments (Please provide any additional information relevant to your request)

Request for Reconsideration for Measure C30 – Call Center – Foreign Language Interpreter and TTY Availability based on incorrect data set used to calculate star rating that included call #C0600900 received 2/9/23

For call C0600900, there was a technical issue caused by the CMS caller's deviation from protocol that ultimately caused the call to exceed the 8 minute threshold. The issue was that the CMS caller did not ask the question clearly, including a stumble at the start, and speaking unusually slowly and stating the plan name in a non-standard manner that the interpreter had trouble understanding. The English translation of the CMS caller's question asked was "are you the per.....are you the right person to answer questions about the medical advantages of.....uhhh.....Village Health.....H-M-O.....P-O-S.....C.....S-N-P?" [The dots represent pauses the CMS caller made in speaking] The total time taken to ask the question from beginning to end was 25 seconds, which demonstrates how long the pauses were. The CMS caller's phrasing of the question and the way it was asked, specifically the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. It was the additional 34 second delay caused by the question needing to be repeated that ultimately caused the call to exceed the 8 minute threshold.

For comparison purposes, we have also attached a recording of another French language interpreter availability assessment call that we received this year (C1201277 that we received on 3/24/2023). In call C1201277, the CMS caller asked the same question more clearly without the stumbling and excessively slow spelling out of the plan name (which was the exact same plan name as in call C0600900). The total time taken to ask the question was just 17 seconds and did not result in the interpreter needing to have the question repeated in order to translate. The total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 41 seconds.

For call C0600900, the total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 86 seconds – 45 seconds longer than in call C1201277 where the caller did not stumble through the question and was much clearer. The failed call missed the time cutoff by 31 seconds. Thus, were it not for the additional delay caused by the non-standard way the C0600900 CMS caller asked the question, call C0600900 would have passed and not failed. Additionally, in spite of the 25 seconds it took just to ask the standard question in call C0600900, if you exclude the additional time associated with the question having to be repeated (34 seconds), the call would have been completed within the time limit. The technical specifications for this measure C30 – Call Center – Foreign Language Interpreter and TTY Availability state that "For the interpreter availability measure to be complete, the CSR, with the interpreter's help, must be able to respond "yes" to the introductory question before the 8-minute timer expires." Time delays that are caused by the CMS caller asking the question in a non-standard way, and thus causing confusion on the part of the interpreter and the need for the call to be repeated, should not be included in the evaluation of a specific call success. Thus, we believe that this call was incorrectly included as a failure in our data and should be reversed to be counted as a completed call since the time in excess of 8 minutes was due to the CMS's caller's failure to follow established CMS protocols. At a minimum, the non-standard way the question was asked should warrant exclusion of this call from the dataset for this measure. CMS mischaracterized the call as a failure, and this data inaccuracy led to a calculation error for our performance on the C30 measure.

Additional Note
It is also worth noting that another possible contributor to the problem with call C0600900 was a technical issue with the standard question asked – specifically, that the question asked was not consistent with the standard question outlined in the Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes. Page 17 of the technical notes state that the introductory question asked by CMS callers is "are you the right person to answer questions about [Plan name's] health benefits?" However, in call C0600900, the CMS caller framed the question in a way different than what is identified in the technical notes. The caller asked "are you the right person to answer questions about the medical advantages of [Plan name]." When dealing with Medicare Advantage products, asking the question with "medical advantages" right before the Plan name can cause additional confusion for the interpreter, and was a proximate cause of call C0600900 exceeding the 8 minute time limit. Where a deviation from the published CMS protocols by CMS or its contractor is the cause of an MA plan exceeding the 8 minute threshold, it is not appropriate for CMS to penalize the MA plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1129 and form number CMS-10346 (Expires: 8/31/2024). The time required to complete this information collection is estimated to average 8 hours, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE DRUG BENEFIT AND C & D DATA GROUP

DATE: November 16, 2016

TO: All Medicare Advantage Organizations, Prescription Drug Plan Sponsors and Medicare-Medicaid Plans (MMPs) (excluding PACE contracts, Cost contracts, and employer-only plans)

FROM: Amy Larrick Chavez-Valdez, Director, Medicare Drug Benefit and C & D Data Group

SUBJECT: 2017 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies

The Centers for Medicare & Medicaid Services (CMS) will continue monitoring Part C and Part D call centers in 2017. This memo describes the elements CMS will monitor and explains how to prepare for the monitoring studies, including updating the Health Plan Management System (HPMS) with critical 2017 call center information **no later than January 2, 2017**.

Call Center Monitoring Background
In 2017, CMS has contracted with IMPAQ International, LLC, to monitor plan sponsors' call centers to ensure compliance with CMS call center standards.[1] CMS conducts two studies which are each described below.

The **Timeliness Study** measures Part C, Part D, and Medicare-Medicaid Plans' (MMP) current enrollee beneficiary call center phone lines and pharmacy technical help desk lines to determine **average hold times** and **disconnect rates**. This study is conducted year round, with quarterly compliance actions taken when an organization fails to maintain an average hold time of 2 minutes or less and/or when an organization has an average disconnect rate greater than 5%. Note that thresholds are adjusted for margin of error.

Part C and D sponsors and MMPs will receive a compliance action for the **Timeliness Study** if, after the adjustment for margin of error, it fails to maintain an average hold time of 2 minutes or less and to limit the disconnect rate of all incoming calls to five (5) percent or less.

Results will be available quarterly through the HPMS at the following paths:

1. For Part C results, from the HPMS home page: Quality and Performance - Performance Metrics - Call Center Monitoring - Part C Beneficiary Customer Service - [select time period] - [enter the contract number]. Please look at column "G" for average hold time data and column "M" for disconnect rate data.

[1] 42 C.F.R. § 422.111(h)(1); 42 C.F.R. § 423.128(d)(1); Medicare Managed Care Manual, Chapter 3; Medicare Prescription Drug Benefit Manual, Chapter 2; and Medicare Marketing Guidelines (June 10, 2016), 30.5, 80, Appendix 3.

2. For Part D results, from the HPMS home page: - Quality and Performance - Performance Metrics - Call Center Monitoring - Part D Beneficiary Customer Service - [select time period] - [enter the contract number]. Please look at column "G" for average hold time data and column "M" for disconnect rate data.

3. For Pharmacy technical help desk results, from the HPMS home page: - Quality and Performance - Performance Metrics - Call Center Monitoring - Pharmacy Support Customer Service - [select time period] - [enter the contract number]. Please look at column "G" for average hold time data and column "M" for disconnect rate data.

The **Accuracy and Accessibility Study** measures Part C, Part D, and MMPs' prospective enrollee beneficiary call center phone lines to determine (1) the **availability of interpreters**[2] for individuals, (2) **TTY functionality**[3]**,** and (3) the **accuracy**[4] **of plan information provided by customer service representatives** (CSRs) in all languages.[5] This study is conducted from approximately February through May, and compliance actions will be taken when an organization's interpreter availability is less than 75%, its TTY service score is lower than 65%, or its rate of accurately answering questions is below 75%.

Overall results will be provided via HPMS and announced via an HPMS email. Informational notices will not be issued in 2017, so compliance officers should watch for the HPMS announcement and review the results in HPMS carefully. Organizations may download the raw data/call detail files directly from HPMS. Upon request, CMS will consider challenges to the data for miscalculations or the use of incorrect data sets. **CMS will not consider challenges premised on methodology or an organization's own internal monitoring results.**

Detailed results (e.g., number of calls by language, number of questions answered correctly, number of successful TTY calls, etc.) will be available in the HPMS at the following paths:

1. For Part C results, from the HPMS home page: Quality and Performance - Performance Metrics - Call Center Monitoring - Part C Prospective Beneficiary Customer Service - [enter the contract number].

2. For Part D results, from the HPMS home page: Quality and Performance - Performance Metrics - Call Center Monitoring - Part D Prospective Beneficiary Customer Service - [enter the contract number].

Compliance

As stated above, compliance actions will be taken when an organization fails to maintain an average hold time of 2 minutes or less, has an average disconnect rate greater than 5%, has an interpreter availability score lower than 75%, has a TTY service score lower than 65%, or has a rate of accurately

---

[2] Interpreter availability is defined as the percent of time that a caller was able to reach someone who could speak the caller's language and ask that person questions. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) A call is considered successful when the caller confirms that the CSR is able to assist in that language. A call is considered complete when establishing contact with an interpreter and beginning the first of three survey questions within eight minutes of reaching a CSR. The number of completed calls out of all foreign language calls is used for compliance as well as star ratings measures.

[3] TTY functionality is defined as the percent of the time a caller using a TTY device was able to communicate with someone who could answer questions either at the sponsor's call center or via a relay operator. A successful call denotes a caller confirming that a CSR is able to assist within 7 minutes, and then beginning the first of three general Medicare or plan-specific questions via the plan's TTY device or relay operator. The number of successful calls out of all TTY calls is used for compliance as well as star ratings measures.

[4] Contracts with *only* Special Needs Plans (SNPs) are excluded from the accuracy measure.

[5] Languages tested in 20176 will be Spanish, Cantonese, Mandarin, Vietnamese, French, and Tagalog; English will be tested as a foreign language for organizations with a service area exclusively in Puerto Rico.

answering questions lower than 75%. Note that thresholds are adjusted for margin of error. Compliance actions may also be taken in other areas where an organization is either an outlier with respect to other sponsors or so far below CMS' reasonable expectations that notice is warranted in order to ensure that the organization provides current and prospective enrollees with the services to which they are entitled. These areas include, but are not limited to, inappropriate call center closures (i.e., closed during business hours) and failure to maintain a toll-free telephone number for that organization's enrollees.

IMPORTANT ACTION: Verify 2017 Call Center Information
All applicable Part C and D sponsors and MMPs should prepare for this monitoring effort by verifying the accuracy of their 2017 Part C and Part D call center phone numbers in HPMS by **January 2, 2017**. Organizations need to review and update their current and prospective enrollee **toll-free** beneficiary call center phone numbers**, toll-free** pharmacy help desk numbers, and current and prospective enrollee **toll-free** TTY numbers. Phone numbers are extracted from HPMS on a biweekly basis and updated in the monitoring contractor's automated dialing software. If any of the phone numbers change during the year, sponsors must immediately update their phone numbers in HPMS. CMS strongly encourages you to keep your phone numbers up to date in HPMS at all times. **If an organization achieves poor results on the measures due to inaccurate telephone numbers, the results will not be negated.** Use the paths outlined below to verify and/or update the phone numbers.

Verify your pharmacy technical help desk number, which is a contract-level contact and not a bid-level contact, use the following path: HPMS home page - contract management - basic contract management – select contract number – *click or type contract number* - contact data - Pharmacy Technical Help Desk Contact.

Verify current and prospective enrollee numbers and TTY numbers through the following path: *HPMS home page - Plan Bids - Bid Submission - Manage Plans - Edit Contact Data* (complete steps listed below).

Follow these steps when editing contact information in the HPMS:

1. In the right-hand **Bid Submission** menu, under **Manage Plans**, click **Edit Contact Data.**

2. On the **Select a Contract** screen, enter a contract number into the field provided (Option 1) or select a contract number (Option 2). Click **Next** to advance to the Update and Save Data screen.

3. On the **Update and Save Data** screen, select a plan, and select a contact tab.

4. Edit the mailing address, telephone numbers, and e-mail address for that contact, if applicable.

5. After entering data for the first contact type, the user can complete data entry for other contact types under the same plan by one of two methods.

Notes:

- The required fields (denoted with an asterisk) vary depending on the type of contact. For example, the toll-free phone number is required for Medicare Part D contact types, but is optional for other types in HPMS. *Please recall that the Medicare Marketing Guidelines, Section 80.1, requires Medicare Part C organizations, Medicare Part D organizations, and MMPs to operate a toll-free call center for current and prospective members. MMPs also have state-specific marketing guidance that requires the toll-free number. Appendix 3 of the Medicare Marketing Guidelines requires Part D Sponsors and MMPs to operate a toll-free pharmacy*

technical help call center. MMPs also have state-specific marketing guidance that requires the toll-free number. ***Even if HPMS does not denote this as a required field in your view, having toll-free numbers available is required.***

- All TTY numbers must be either three numeric characters or 10 numeric characters.
- Please make certain you have entered the **TTY Local Phone Number** and the **TTY TOLL-FREE Phone Number**. If your plan does not use a dedicated, in-house TTY device, you may enter 711 in both fields. The toll-free TTY number must be populated, as this is the number we pull for the Accuracy & Accessibility Study. All TTY numbers must be either three numeric characters or 10 numeric characters.

*This information can be found in Chapter 1 of the CY2017 Bid User Manual (*HPMS home page - Plan Bids - Bid Submission - CY2017 - View Documentation - Bid User manual*).

Tips for Success

Based on several years of study results, CMS provides the following tips to help improve results.

HPMS Entries:

- Current, prospective, and TTY customer service call center toll-free telephone numbers must be entered in the appropriate locations in HPMS. There is a toll-free field for TTY or relay telephone numbers. CMS extracts the values found in the toll-free and alternate toll-free fields, so please make sure HPMS reflects accurate contact information and is complete in every field. **If you have updates at any time during the year, please enter them into HPMS immediately. A delay in updating the phone number(s) will result in unsuccessful calls for your plan(s).**
- Contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028 if you require assistance.

Interpreter Availability:

- Utilize an interpretation service to identify the beneficiary's language.
- Use interpreter services personnel who are familiar with healthcare terms and Medicare benefit concepts.
- Train CSRs to connect foreign-language callers with an interpreter.
- Ensure CSRs stay on the phone when a foreign-language interpreter joins the call.
- In order to replicate a beneficiary's actual experience, CMS telephone interviewers who are testing a language other than the primary language will not make a selection in the interactive voice response (IVR) technology if the instruction is only in the primary language. Therefore, **ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu.** If the IVR instruction *is* available in the language being tested, the test callers *will* make an appropriate IVR selection. For example, if the language being tested is French, and instruction is available in French in the IVR to select an option for French, the test caller *will* make that selection. (Please note that the primary language in Puerto Rico is Spanish, and English elsewhere. When testing calls in Puerto Rico, English is considered a foreign language.)
- Because the time is limited to 7 minutes for each of the general accuracy questions, a best practice for CSRs is to speak at a high level first and offer more detail, if asked.
- Include a note on the beneficiary's call center record that indicates his/her preferred language, if other than English.
- Maintain and use a tracking system so that once a beneficiary's language is identified, it is recorded and used for future contacts.
- Monitor CSR calls to ensure that foreign-language calls are being handled according to the sponsor's policies and procedures.

- Ensure that interpreters are available within 8 minutes of the caller reaching a CSR.
- Ensure that CSRs are able to respond promptly to questions. By protocol, each accuracy question has a 7-minute timer.

Ability to Accept Calls:

- If your organization intends to implement any new technology affecting phone systems, ensure it will not interfere with the organization's ability to accept calls.
- Ensure that your organization does not employ IVR logic that will block calls at certain times based solely upon the area code of the caller.
- Carefully review your service areas to ensure you are covering the call center from 8:00 a.m. to 8:00 p.m. for **all** of your plans' local service areas. Check carefully to verify your coverage for any counties that are split into two time zones or to confirm observance of daylight savings time. For example, some contracts will occasionally serve counties that are split into two time zones. Also, most of Arizona is exempt from daylight savings time; however, the Navajo Nation lands, which extend to the states of Arizona, New Mexico and Utah, observe daylight saving time. Regardless of whether two time zones are served or daylight savings time is or is not observed, call centers are required to be open from 8:00 am.to 8:00 p.m. in all local service areas for all of its current or potential enrollees.

TTY Functionality:

- If using an in-house TTY device, regularly test your device to ensure that it is working properly.
- If using an in-house TTY device, have a staffing plan that includes coverage for the TTY device during the hours your call center is required to operate with live CSRs.
- Messages that ask a caller to leave their phone number are not appropriate, and will not be counted as a successful call. Callers need to be able to communicate with a live person when they call.
- Ensure that wait times for a CSR or state relay operator are not lengthy.
- Ensure that CSRs are available within 7 minutes of the time of answer. CMS considers a CSR unavailable if the caller or relay operator is unable to communicate with the CSR.
- Ensure that CSRs or state relay operators are able to respond promptly to questions. By protocol, each accuracy question has a 7-minute timer.

Information Accuracy:

- Ensure that CSRs can respond to questions regarding items listed in the Medicare Marketing Guidelines, Section 80.1.
- Review the 2017 edition of *Medicare & You* to ensure your CSRs are trained on new Part C and Part D benefit information for 2017.
- CSRs should have specific plan benefit package (PBP) level benefit and formulary data easily available.

Guidance for Providing Services to Limited English Proficient Beneficiaries

CMS reminds organizations of the HHS Office of Minority Health's (OMH) *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (*National CLAS Standards*). Originally published in 2000, an enhanced version of the HHS *National CLAS Standards* was released by OMH in April 2013. The *National CLAS Standards* offer health and health care organizations 15 action steps for providing culturally and linguistically appropriate services. The *National CLAS Standards* are intended to advance health equity, improve quality, and help eliminate health care disparities. The Principal Standard is to "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred

languages, health literacy, and other communication needs" and serves as the overarching goal for *National CLAS Standards'* implementation. One key area is Communication and Language Assistance, which includes: offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services (Standard 5); informing all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing (Standard 6); ensuring the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided (Standard 7); and providing easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area (Standard 8). The *National CLAS Standards* are available at www.ThinkCulturalHealth.hhs.gov/clas. CMS strongly encourages sponsors to review and utilize the OMH *National CLAS Standards* and its guidance document, *The Blueprint*. If you have any questions about the OMH *National CLAS Standards*, please contact AdvancingCLAS@ThinkCulturalHealth.hhs.gov.

Call Center Monitoring Reference Materials

The recording of the 2016 Call Center Monitoring Webinar held on February 3, 2016 is available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/index.html under "Related Links." Please see the link for "2016 Part C and Part D Call Center Meeting." The slide deck is available under the "Downloads" section. Please see "2016 Call Center Monitoring Slides Script Questions and Answers." As updated training materials become available, they will be added to this web page and announced via an HPMS email.

If you have any questions about the 2017 call center monitoring effort, please contact the Call Center Monitoring mailbox at CallCenterMonitoring@cms.hhs.gov.

TAB 24

From: Michael Plumb
To: CMS QBPAPPEALS
Cc: Renee Delphin-Rodriguez
Subject: QBP Informal Hearing Request Form for SCAN Health Plan (H5425)
Date: Thursday, February 29, 2024 1:55:09 PM
Attachments: Attachment B-Informal Hearing_Form_2025 SCAN Health Plan H5245.xlsm
SCAN H5245 Informal Hearing Request Justification.docx
QBP Reconsideration Form for SCAN Health Plan (H5425).msg
C0600900.zip
C0600900_Transcript.pdf
C1201277_Transcript.pdf

Attached please find SCAN Health Plan's Request for an Informal Hearing for MAPD contract H5425. Please note that in addition to the Informal Hearing Request form (excel file), we have attached several additional documents:

- A Microsoft Word file that contains our reasoning for the request for the informal hearing, since it does not fit in the cell for "Additional Comments" in the Excel Form in row 69 [
- The email request for reconsideration submitted on November 9th, 2023, which included the following:
    - Excel based request for reconsideration form
    - A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text pasted into the Excel form).
    - An additional file (.wav format) that includes a recording of a call (#C1201277) that we referenced in our justification for reconsideration.
- An additional ZIP file that contains the ".wav" format recording of the call (#C0600900) that is the focus for our appeal.
- A certified translation of call #C0600900, the call we are appealing
- A certified translation of call #C1201277, a reference call that is included in our appeal justification

Please let us know if you have any questions, or if you have any issues opening any of the files given the size of this email. I know there was some difficulty previously opening the .wav file.

Also, to ensure CMS receipt of this request for an informal hearing, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Friday, November 10, 2023 12:14 AM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: QBP Reconsideration Form for SCAN Health Plan (H5425)

Attached please find SCAN Health Plan's Request for Reconsideration for MAPD contract H5425. Please note that in addition to the Excel form, we have attached two additional forms:

- An additional file (.wav format) that includes a recording of a call that we referenced in our justification for reconsideration.
- A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text pasted into the Excel form).

Please let us know if you have any questions.

Also, to ensure CMS receipt of this request for reconsideration, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or

phone. Thank you for your prompt attention in this matter.

Attachment B - Request for Informal Hearing

Note: The QBP administrative review process is a two-step process which includes: 1) a request for reconsideration, and 2) a request for an informal hearing after CMS has rendered its reconsideration decision. Both steps are conducted at the contract level. The burden is on the MA organization to prove that the reconsideration decision was incorrect.

Instructions: Use only the "Request for Informal Hearing" form provided with the reconsideration decision. One form must be submitted for each contract for which reconsideration is requested. Complete the identifiable information including all contact information. Please enable Macros in this form. Mark an "X" next to the measure(s) that is the basis for the Request for Informal Hearing. Do not mark any measures for which you did not request a reconsideration. Please attach full documentation that supports your request for an informal hearing on the record. Save the information, include your contract number in the filename, and e-mail the completed form along with any additional documentary evidence to be considered to QBPAPPEALS@cms.hhs.gov by the due date.

Due Date: A Request for Informal Hearing is made by completing this form and e-mailing the form to QBPAPPEALS@cms.hhs.gov by 5:00 p.m. EST on February 29, 2024. No late requests will be accepted.

Contract Number (5 character CMS assigned code):	H5425
Contact First Name (your first name):	Michael
Contact Last Name (your last name):	Plumb
Contact Title (your job title):	Chief Financial Officer
Contact Phone Number (your phone number, include extension if necessary):	714-655-9202
Contact email address (your email address):	mplumb@scanhealthplan.com

Overall Rating	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
QBP/Overall Rating	Star Ratings		Not Appealable	

Part C Measures	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
C01-Breast Cancer Screening	HEDIS		Not Appealable	
C02-Colorectal Cancer Screening	HEDIS		Not Appealable	
C03-Annual Flu Vaccine	CAHPS		Not Appealable	
C04-Monitoring Physical Activity	HEDIS / HOS		Not Appealable	
C05-Special Needs Plan (SNP) Care Management	Part C Plan Reporting		Not Appealable	
C06-Care for Older Adults – Medication Review	HEDIS		Not Appealable	
C07-Care for Older Adults – Pain Assessment	HEDIS		Not Appealable	
C08-Osteoporosis Management in Women who had a Fracture	HEDIS		Not Appealable	
C09-Diabetes Care – Eye Exam	HEDIS		Not Appealable	
C10-Diabetes Care – Blood Sugar Controlled	HEDIS		Not Appealable	
C11-Controlling Blood Pressure	HEDIS		Not Appealable	
C12-Reducing the Risk of Falling	HEDIS / HOS		Not Appealable	
C13-Improving Bladder Control	HEDIS / HOS		Not Appealable	
C14-Medication Reconciliation Post-Discharge	HEDIS		Not Appealable	
C15-Plan All-Cause Readmissions	HEDIS		Not Appealable	
C16-Statin Therapy for Patients with Cardiovascular Disease	HEDIS		Not Appealable	
C17-Transitions of Care	HEDIS		Not Appealable	
C18-Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS		Not Appealable	
C19-Getting Needed Care	CAHPS		Not Appealable	
C20-Getting Appointments and Care Quickly	CAHPS		Not Appealable	
C21-Customer Service	CAHPS		Not Appealable	
C22-Rating of Health Care Quality	CAHPS		Not Appealable	
C23-Rating of Health Plan	CAHPS		Not Appealable	
C24-Care Coordination	CAHPS		Not Appealable	
C25-Complaints about the Health Plan	CTM		Not Appealable	
C26-Members Choosing to Leave the Plan	MBDSS		Not Appealable	
C27-Health Plan Quality Improvement	Star Ratings		Not Appealable	
C28-Plan Makes Timely Decisions about Appeals	IRE			
C29-Reviewing Appeals Decisions	IRE			
C30-Call Center – Foreign Language Interpreter and TTY Availability	Call Center		X	We beleive incorrect data was used in the calculation for this measure given that one of the foreign language interpreter availability calls (C0600900) is incorrectly included in our results based on a technical issue associated with the non-standard manner in which the CMS caller asked the standard question. Please see the additional comments section below for the explanation.

Attachment A

Part D Measures	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
D01-Call Center – Foreign Language Interpreter and TTY Availability	Call Center			
D02-Complaints about the Drug Plan	CTM	Not Applicable	Not Applicable	Not appealable, use Part C measure C25 above.
D03-Members Choosing to Leave the Plan	MBDSS	Not Applicable	Not Applicable	Not appealable, use Part C measure C26 above.
D04-Drug Plan Quality Improvement	Star Ratings		Not Appealable	
D05-Rating of Drug Plan	CAHPS		Not Appealable	
D06-Getting Needed Prescription Drugs	CAHPS		Not Appealable	
D07-MPF Price Accuracy	PDE, MPF Pricing		Not Appealable	
D08-Medication Adherence for Diabetes Medications	PDE		Not Appealable	
D09-Medication Adherence for Hypertension (RAS antagonists)	PDE		Not Appealable	
D10-Medication Adherence for Cholesterol (Statins)	PDE		Not Appealable	
D11-MTM Program Completion Rate for CMR	Part D Plan Reporting		Not Appealable	
D12-Statin Use in Persons with Diabetes (SUPD)	PDE data		Not Appealable	

Additional Comments (Please provide any additional information relevant to your request)

Request for Informal Hearing related to SCAN Health Plan H5245 for Measure C30 – Call Center – Foreign Language Interpreter and TTY Availability based on incorrect data set used to calculate star rating that included call #C0600900 received 2/9/23.

We incorporate by reference and renew each and every one of our prior objections stated in our Request for Reconsideration for Measure C30 (attached hereto) based on the incorrect data set used to calculate SCAN's Star Rating that included call #C0600900 received by SCAN Health on 2/9/23. As detailed in our prior Request for Reconsideration, for call C0600900, there was a technical issue caused by the CMS caller that ultimately caused the call to exceed the 8 minute threshold: the CMS caller did not ask the question clearly, including multiple stumbles, speaking unusually slowly, and stating the plan name in a non-standard manner such that the interpreter had trouble understanding, requiring further clarification, and creating significant and unnecessary delay. Unfortunately, CMS's Reconsideration Decision ("Technical Report for SCAN Health Plan H5425") fails to meaningfully address the critical problems detailed in our Request for Reconsideration. We renew those same objections, as further detailed herein.

First: At Page 4 in the Reconsideration Decision, CMS states that "SCAN requests that call C0600900 be reclassified as a successful call in their results. This would adjust their score for measure C30 from 96% (4 stars) to 97% (5 stars)." To be clear: We requested, and now request again, that the call be either counted as a successful ("completed") call OR excluded from the C30 Star Rating measure. Either approach would result in SCAN Health's measure Star Rating increasing from 4 to 5 stars, and its overall Star Rating increasing to 4 Stars. This would result in SCAN qualifying for a quality bonus payment, as CMS rewards Medicare Advantage plans rated "4 stars or higher" with a quality bonus payment. See, e.g., 42 U.S.C. § 1396w-23(o)(1), (3)(A)(i).

Second: SCAN previously argued that the result of the call C0600900 was impacted by how the caller asked the question, which was not consistent with CMS's standard protocol, causing confusion on the part of the interpreter; the caller's speech resulted in the question needing to be repeated, and thus led to the call exceeding the time limit. The Reconsideration Decision states that CMS "disagree[s] with [SCAN's] assertion that the caller deviated from the standard protocol," and includes a table (at 5-6) purporting to document the translation of the secret shopper's statements. Line 4 and 5 of the table include the following:

"4. Exactly what the interviewer actually asked in French: Bonjour. Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de Village Health HMO POS D-SNP? 5. Exactly what the interviewer actually asked translated to English: Hello. Are you the right person to answer questions about health benefits of Village Health HMO POS D-SNP?"

But what is listed in line 4 of the table is not "exactly what the interviewer asked in French." CMS ignores the manner in which the question was delivered. SCAN outlined in its original request for reconsideration "exactly what the interviewer actually asked in French," with the secret shopper restarting the question and many long pauses, which caused the confusion for the interpreter and caused the need for the question to be repeated, which added over 34 seconds of time to the call and caused it to exceed the time limit. We encourage the reviewer to listen to the actual call to see why the description above does not appropriately represent the nature of the question:

French: Bonjour. "Êtes-vous la per……Êtes-vous la personne adéquate pour répondre aux questions concernant les avantages médicaux….de…uh…Village Health…..H-M-O……P-O-S….C…..S-N-P?"

It took 25 seconds for the CMS caller to complete the question, because of the stumble, the need to start over, and the long pauses. The total elapsed time for the CMS caller to say "HMO POS CSNP" was 11 seconds. CMS claims in its Reconsideration Decision that "CMS callers are trained to ask questions in a conversational way" – but the way the CMS caller asked the question with the long pauses was not conversational at all. Thus, the interpreter was confused by the caller's slow reading of the individual letters in the plan name, and it was not clear that the caller was speaking the name of the plan. After the interpreter asks for the latter part of the question to be repeated, the CMS caller even goes so far as to clarify that it's the name of the plan ("the nom de plan") before she repeats it again. It is indisputable that the manner in which the question was asked caused confusion. Without that secret shopper's delay caused by the non-standard manner in which the question was asked, the call would have been completed within the 8-minute time limit, even with the amount of time it took to get the interpreter on the line.

Third: In our Request for Reconsideration, we included a recording of another French call (C1201277 that we received on 3/24/2023, attached hereto) where the exact same question was asked with the same plan name, and the CMS caller did ask the question in a conversational way without long pauses. The question was asked in 17 seconds (32% less time) and the plan name was very clear, and the interpreter had no issue understanding the question and did not need to ask for it to be repeated. CMS claims in the denial justification that "CMS asked the same question on both calls, and any difference in the way they were stated is down to the individual caller." But CMS also argues that "CMS callers are trained to ask the question in a conversational way." The way in which the challenged CMS caller asked the question was non-standard and caused confusion for the interpreter that led to the delay that caused the call to exceed the time limit. The Reconsideration Decision fails to provide any non-arbitrary rationale for its disparate treatment of call C0600900 and C1201277, with CMS stating (at 7) that any "differences in the way they [the questions] were stated is down to the individual caller, just like a non-test call would be, which is what CMS is testing." But that is exactly the point: CMS cannot provide any non-arbitrary justification for why SCAN Health should be penalized based on "differences in the way they [the questions] were stated [by] the individual caller." Indeed, CMS has taken the position elsewhere that it would not penalize Medicare Advantage plans for delays and confusion introduced even by interpreters in answering questions, as CMS "wouldn't hold that against you" and would not "count against you." 2016 CMS Call Center Monitoring Q&A at 3, https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting

Fourth: CMS's Reconsideration Decision also references that "SCAN's argument ignores the fact that it took over six and a half minutes for the interpreter to join the call to begin with." This is not an accurate representation of SCAN's argument at all. SCAN fully understands that it took that 6 minute and 35 seconds to get an interpreter on the line. SCAN would ask one simple question of the informal hearing reviewer:

Is 1 minute and 25 seconds enough time to complete the cycle of the CMS caller asking the standard question and getting the appropriate response from the customer service representative?

In its Reconsideration Decision, CMS ignores the fact that it is completely possible, and typical, to still have a successful call even in such a scenario, and CMS irrationally takes the position that if there is anything else irregular or inappropriate about the call, that the cause of the call failure is solely attributable to the time it took to get the interpreter on the line. That is not a fair and reasonable position – 1 minute and 25 seconds is more than enough time for the cycle to be completed when the standard question is asked clearly and appropriately. The reference call that we provided, C1201277, took 41 seconds to complete that cycle. The failed French call, C0600900, took 86 seconds to complete the cycle – 45 seconds longer than in call C1201277. Variations in individual callers should not result in it taking twice as much time to complete the cycle. This was not a normal variation in a conversational way of asking the standard question. 1 minute and 25 seconds is clearly sufficient to respond to a properly posed question, had the CMS caller posed one.

Fifth: In the Reconsideration Decision, CMS also includes 2023 statistics about the number of French calls to all plans, as well as to SCAN specifically, and claims that CMS asks the same question on all calls. That argument is not relevant to our reconsideration request - SCAN is not contending that CMS asks different questions on each call. SCAN is contending that the manner in which the CMS caller asked the question for the specific call in question was non-standard, given the stumbling and the long pauses, and inconsistent with the secret shopper's clearer manner of speech on call C1201277. The manner in which the question was asked caused the confusion for the interpreter that led to the delay that caused the call to exceed the time limit.

CMS goes on to argue in its denial justification that "call C0600900 is the only French language call that has been questioned for this year's study around the issue of how the introductory question was asked." That argument is also not relevant to SCAN's argument presented in our reconsideration. We are not questioning all other French calls. We are simply contending that for call C0600900, the question was asked in a non-standard manner that caused confusion for the interpreter, which led to the delay that cause the call to exceed the time limit.

In summary: As stated in our Request for Reconsideration, for call C0600900, the CMS caller's phrasing of the question and the way it was asked, including the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. The non-standard manner the question was asked resulted in an additional 34 seconds of time given the need to repeat the question. Without that 34-second delay caused by the non-standard manner in which the question was asked, the call would have been completed within the 8-minute time limit, even with the amount of time it took to get the interpreter on the line. That is why the call should either be deemed a successful call, or at a minimum, excluded from the sample for this star measure.

Additionally: The Reconsideration Decision asserts (at 2) that measure C30 is used to "ensure compliance with regulatory requirements, found at 42 C.F.R. §§ 422.111(h)." But the regulation upon which CMS relies states that "interpreters must be available for 80 percent of incoming calls requiring an interpreter within 8 minutes of reaching the customer service representative." Here, SCAN Health did have an interpreter "available" within 8 minutes of the caller reaching the customer service representative: The interpreter introduced himself at 6 minutes 35 seconds, and spent the remaining time in an interactive dialogue with the caller to interpret her question. "Available" simply means an interpreter is "present or ready for immediate use." Available, Merriam-Webster Dictionary (2024); see also United States v. Soybel, 13 F.4th 584, 595 (7th Cir. 2021) ("available" means "present or ready for immediate use"). That standard was clearly met here: The caller was "connected to an interpreter within 8 minutes," i.e., at 6:35. 86 Fed. Reg. 6007, 6007-08 (2021). Here, there is an arbitrary misalignment between CMS's stated goal in its regulation (to ensure that an interpreter is available, i.e. connected, within 8 minutes) and the rationale for its Reconsideration Decision (requiring SCAN Health to complete answering a caller's question within 8 minutes).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1129 and form number CMS-10346 (Expires: 8/31/2024). The time required to complete this information collection is estimated to average 8 hours, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

We incorporate by reference and renew each and every one of our prior objections stated in our Request for Reconsideration for Measure C30 (attached hereto) based on the incorrect data set used to calculate SCAN's Star Rating that included call #C0600900 received by SCAN Health on 2/9/23. As detailed in our prior Request for Reconsideration, for call C0600900, there was a technical issue caused by the CMS caller that ultimately caused the call to exceed the 8 minute threshold: the CMS caller did not ask the question clearly, including multiple stumbles, speaking unusually slowly, and stating the plan name in a non-standard manner such that the interpreter had trouble understanding, requiring further clarification, and creating significant and unnecessary delay. Unfortunately, CMS's Reconsideration Decision ("Technical Report for SCAN Health Plan H5425") fails to meaningfully address the critical problems detailed in our Request for Reconsideration. We renew those same objections, as further detailed herein.

First: At Page 4 in the Reconsideration Decision, CMS states that "SCAN requests that call C0600900 be reclassified as a successful call in their results. This would adjust their score for measure C30 from 95% (4 stars) to 97% (5 stars)." To be clear: We requested, and now request again, that the call be either counted as a successful ("completed") call OR excluded from the C30 Star Rating measure. Either approach would result in SCAN Health's measure Star Rating increasing from 4 to 5 stars, and its overall Star Rating increasing to 4 Stars. This would result in SCAN qualifying for a quality bonus payment, as CMS rewards Medicare Advantage plans rated "4 stars or higher" with a quality bonus payment. *See, e.g.*, 42 U.S.C. § 1395w-23(o)(1), (3)(A)(i).

Second: SCAN previously argued that the result of the call C0600900 was impacted by how the caller asked the question, which was not consistent with CMS's standard protocol, causing confusion on the part of the interpreter; the caller's speech resulted in the question needing to be repeated, and thus led to the call exceeding the time limit. The Reconsideration Decision states that CMS "disagree[s] with [SCAN's] assertion that the caller deviated from the standard protocol," and includes a table (at 5-6) purporting to document the translation of the secret shopper's statements. Line 4 and 5 of the table include the following:

> *"4. Exactly what the interviewer actually asked in French: Bonjour. Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de Village Health HMO POS D-SNP? 5. Exactly what the interviewer actually asked translated to English: Hello. Are you the right person to answer questions about health benefits of Village Health HMO POS D-SNP?"*

But what is listed in line 4 of the table is not "exactly what the interviewer asked in French." CMS ignores the manner in which the question was delivered. SCAN outlined in its original request for reconsideration "exactly what the interviewer actually asked in French," with the secret shopper restarting the question and many long pauses, which caused the confusion for the interpreter and caused the need for the question to be repeated, which added over 34 seconds of time to the call and caused it to exceed the time limit. We encourage the reviewer to listen to the actual call to see why the description above does not appropriately represent the nature of the question:

French: Bonjour. "Êtes-vous la per…….Êtes-vous la personne adéquate pour répondre aux questions concernant les avantages médicaux…..de…uh….Village Health….. H-M-O……P-O-S…. C…..S-N-P?"

It took 25 seconds for the CMS caller to complete the question, because of the stumble, the need to start over, and the long pauses. The total elapsed time for the CMS caller to say "HMO POS CSNP" was 11 seconds. CMS claims in its Reconsideration Decision that "CMS callers are trained to ask questions in a conversational way" – but the way the CMS caller asked the question with the long pauses was not conversational at all. Thus, the interpreter was confused by the caller's slow reading of the individual letters in the plan name, and it was not clear that the caller was speaking the name of the plan. After the interpreter asks for the latter part of the question to be repeated, the CMS caller even goes so far as to clarify that it's the name of the plan ("the nom de plan") before she repeats it again. It is indisputable that the manner in which the question was asked caused confusion. Without that secret shopper's delay caused by the non-standard manner in which the question was asked, the call would have been completed within the 8-minute time limit, even with the amount of time it took to get the interpreter on the line.

Third: In our Request for Reconsideration, we included a recording of another French call (C1201277 that we received on 3/24/2023, attached hereto) where the exact same question was asked with the same plan name, and the CMS caller did ask the question in a conversational way without long pauses. The question was asked in 17 seconds (32% less time) and the plan name was very clear, and the interpreter had no issue understanding the question and did not need to ask for it to be repeated. CMS claims in the denial justification that "CMS asked the same question on both calls, and any difference in the way they were stated is down to the individual caller." But CMS also argues that "CMS callers are trained to ask the question in a conversational way." The way in which the challenged CMS caller asked the question was non-standard and caused confusion for the interpreter that led to the delay that caused the call to exceed the time limit. The Reconsideration Decision fails to provide any non-arbitrary rationale for its disparate treatment of call C0600900 and C1201277, with CMS stating (at 7) that any "differences in the way they [the questions] were stated is down to the individual caller, just like a non-test call would be, which is what CMS is testing." But that is exactly the point: CMS cannot provide any non-arbitrary justification for why SCAN Health should be penalized based on "differences in the way they [the questions] were stated [by] the individual caller." Indeed, CMS has taken the position elsewhere that it would not penalize Medicare Advantage plans for delays and confusion introduced even by interpreters in answering questions, as CMS "wouldn't hold that against you" and would not "count against you." 2016 CMS Call Center Monitoring Q&A at 3, https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting

Fourth: CMS's Reconsideration Decision also references that "SCAN's argument ignores the fact that it took over six and a half minutes for the interpreter to join the call to begin with." This is not an accurate representation of SCAN's argument at all. SCAN fully understands that it took that 6 minute and 35 seconds to get an interpreter on the line. SCAN would ask one simple question of the informal hearing reviewer:

Is 1 minute and 25 seconds enough time to complete the cycle of the CMS caller asking the standard question and getting the appropriate response from the customer service representative?

In its Reconsideration Decision, CMS ignores the fact that it is completely possible, and typical, to still have a successful call even in such a scenario, and CMS irrationally takes the position that if there is anything else irregular or inappropriate about the call, that the cause of the call failure is solely attributable to the time it took to get the interpreter on the line. That is not a fair and reasonable position – 1 minute and 25 seconds is more than enough time for the cycle to be completed when the standard question is asked clearly and appropriately. The reference call that we provided, C1201277, took 41 seconds to complete that cycle. The failed French call, C0600900, took 86 seconds to complete the cycle – 45 seconds longer than in call C1201277. Variations in individual callers should not result in it taking twice as much time to complete the cycle. This was not a normal variation in a conversational way of asking the standard question. 1 minute and 25 seconds is clearly sufficient to respond to a properly posed question, had the CMS caller posed one.

Fifth: In the Reconsideration Decision, CMS also includes 2023 statistics about the number of French calls to all plans, as well as to SCAN specifically, and claims that CMS asks the same question on all calls. That argument is not relevant to our reconsideration request - SCAN is not contending that CMS asks different questions on each call. SCAN is contending that the manner in which the CMS caller asked the question for the specific call in question was non-standard, given the stumbling and the long pauses, and inconsistent with the secret shopper's clearer manner of speech on call C1201277. The manner in which the question was asked caused the confusion for the interpreter that led to the delay that caused the call to exceed the time limit.

CMS goes on to argue in its denial justification that “call C0600900 is the only French language call that has been questioned for this year’s study around the issue of how the introductory question was asked.” That argument is also not relevant to SCAN’s argument presented in our reconsideration. We are not questioning all other French calls. We are simply contending that for call C0600900, the question was asked in a non-standard manner that caused confusion for the interpreter, which led to the delay that cause the call to exceed the time limit.

In summary: As stated in our Request for Reconsideration, for call C0600900, the CMS caller’s phrasing of the question and the way it was asked, including the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. The non-standard manner the question was asked resulted in an additional 34 seconds of time given the need to repeat the question. Without that 34-second delay caused by the non-standard manner in which the question was asked, the call would have been completed within the 8-minute time limit, even with the amount of time it took to get the interpreter on the line. That is why the call should either be deemed a successful call, or at a minimum, excluded from the sample for this star measure.

Additionally: The Reconsideration Decision asserts (at 2) that measure C30 is used to "ensure compliance with regulatory requirements, found at 42 C.F.R. §§ 422.111(h)." But the regulation upon which CMS relies states that "interpreters must be available for 80 percent of incoming calls requiring an interpreter within 8 minutes of reaching the customer service representative." Here, SCAN Health did have an interpreter "available" within 8 minutes of the caller reaching the customer service representative: The interpreter introduced himself at 6 minutes 35 seconds, and spent the remaining time in an interactive dialogue with the caller to interpret her question. "Available" simply means an interpreter is "present or ready for immediate use." Available, Meriam-Webster Dictionary (2024); see also United States v. Soybel, 13 F.4th 584, 595 (7th Cir. 2021) ("available" means "present or ready for immediate use"). That standard was clearly met here: The caller was "connected to an interpreter within 8 minutes," i.e., at 6:35. 86 Fed. Reg. 6007, 6007-08 (2021). Here, there is an arbitrary misalignment between CMS's stated goal in its regulation (to ensure that an interpreter is available, i.e. connected, within 8 minutes) and the rationale for its Reconsideration Decision (requiring SCAN Health to complete answering a caller's question within 8 minutes).

From: Michael Plumb
To: CMS QBPAPPEALS
Cc: Moon Leung; Ginette Hawkins; Renee Delphin-Rodriguez
Subject: QBP Reconsideration Form for SCAN Health Plan (H5425)
Date: Friday, November 10, 2023 12:20:11 AM
Attachments: Request_For_Reconsideration_Form_2025 - SCAN Health Plan H5425.xlsm
C1201277_03242023.WAV
Attachment 1. Additional Details To Support QBP Reconsideration v3.docx
Attachment 1. Additional Details To Support QBP Reconsideration.docx

---

Attached please find SCAN Health Plan's Request for Reconsideration for MAPD contract H5425. Please note that in addition to the Excel form, we have attached two additional forms:

- An additional file (.wav format) that includes a recording of a call that we referenced in our justification for reconsideration.
- A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text pasted into the Excel form).

Please let us know if you have any questions.

Also, to ensure CMS receipt of this request for reconsideration, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

Attachment A

Request for Reconsideration

Note: The QBP administrative review process is a two-step process that includes: 1) a request for reconsideration, and 2) a request for an informal hearing after CMS has rendered its reconsideration decision. Both steps are conducted at the contract level. This first step affords an MA organization the opportunity to request a reconsideration of how its Star Rating, for the given measure in question, was calculated. This is not an opportunity for an MA organization to question how every measure was calculated. A request for reconsideration must be submitted by the date and time specified below in order to reserve the right to later request an informal hearing on the record.

Instructions: Use only the "Request for Reconsideration" form that can be found in HPMS. To download a copy of the form from HPMS, select Quality and Performance on the home page, then Performance Metrics. On the Performance Metrics page select Reports, Costs and then MA QBP Rating. One form must be submitted for each contract for which reconsideration is requested. Complete the identifiable information including all contact information. Mark an "X" next to the measure(s) that the MA organization is questioning and requesting reconsideration. In the "Description of the Issue" specify any errors that the MA organization asserts CMS may have made in calculating the contract's QBP determination. Save the information, please include your contract number in the filename and e-mail the completed form along with any additional documentary evidence to be considered to QBPAPPEALS@cms.hhs.gov by the due date.

Due Date: A Request for Reconsideration of QBP is made by completing the Excel version of this form downloaded from HPMS and e-mailing the form to QBPAPPEALS@cms.hhs.gov by 5:00 p.m. EST on November 17, 2023. No late requests will be accepted.

Contract Number (5 character CMS assigned code):	H5425
Contact First Name (your first name):	Michael
Contact Last Name (your last name):	Plumb
Contact Title (your job title):	Chief Financial Officer
Contact Phone Number (your phone number, include extension if necessary):	714-655-9202
Contact email address (your email address):	mplumb@scanhealthplan.com

Overall Rating	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
QBP/Overall Rating	Star Ratings		Not Appealable	

Part C Measures	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
C01-Breast Cancer Screening	HEDIS		Not Appealable	
C02-Colorectal Cancer Screening	HEDIS		Not Appealable	
C03-Annual Flu Vaccine	CAHPS		Not Appealable	
C04-Monitoring Physical Activity	HEDIS / HOS		Not Appealable	
C05-Special Needs Plan (SNP) Care Management	Part C Plan Reporting		Not Appealable	
C06-Care for Older Adults – Medication Review	HEDIS		Not Appealable	
C07-Care for Older Adults – Pain Assessment	HEDIS		Not Appealable	
C08-Osteoporosis Management in Women who had a Fracture	HEDIS		Not Appealable	
C09-Diabetes Care – Eye Exam	HEDIS		Not Appealable	
C10-Diabetes Care – Blood Sugar Controlled	HEDIS		Not Appealable	
C11-Controlling Blood Pressure	HEDIS		Not Appealable	
C12-Reducing the Risk of Falling	HEDIS / HOS		Not Appealable	
C13-Improving Bladder Control	HEDIS / HOS		Not Appealable	
C14-Medication Reconciliation Post-Discharge	HEDIS		Not Appealable	
C15-Plan All-Cause Readmissions	HEDIS		Not Appealable	
C16-Statin Therapy for Patients with Cardiovascular Disease	HEDIS		Not Appealable	
C17-Transitions of Care	HEDIS		Not Appealable	
C18-Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS		Not Appealable	
C19-Getting Needed Care	CAHPS		Not Appealable	
C20-Getting Appointments and Care Quickly	CAHPS		Not Appealable	
C21-Customer Service	CAHPS		Not Appealable	
C22-Rating of Health Care Quality	CAHPS		Not Appealable	
C23-Rating of Health Plan	CAHPS		Not Appealable	
C24-Care Coordination	CAHPS		Not Appealable	
C25-Complaints about the Health Plan	CTM		Not Appealable	
C26-Members Choosing to Leave the Plan	MBDSS		Not Appealable	
C27-Health Plan Quality Improvement	Star Ratings		Not Appealable	
C28-Plan Makes Timely Decisions about Appeals	IRE			
C29-Reviewing Appeals Decisions	IRE			

C30-Call Center – Foreign Language Interpreter and TTY Availability	Call Center		X	We believe incorrect data was used in the calculation for this measure given that one of the foreign language interpreter availability calls (C0600900) is incorrectly included in our results based on a technical issue associated with the non-standard manner in which the CMS caller asked the standard question. Please see the additional comments section below for the explanation.

Part D Measures	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
D01-Call Center – Foreign Language Interpreter and TTY Availability	Call Center			
D02-Complaints about the Drug Plan	CTM	Not Applicable	Not Applicable	Not appealable, use Part C measure C25 above.
D03-Members Choosing to Leave the Plan	MBDSS	Not Applicable	Not Applicable	Not appealable, use Part C measure C26 above.
D04-Drug Plan Quality Improvement	Star Ratings		Not Appealable	
D05-Rating of Drug Plan	CAHPS		Not Appealable	
D06-Getting Needed Prescription Drugs	CAHPS		Not Appealable	
D07-MPF Price Accuracy	PDE, MPF Pricing		Not Appealable	
D08-Medication Adherence for Diabetes Medications	PDE		Not Appealable	
D09-Medication Adherence for Hypertension (RAS antagonists)	PDE		Not Appealable	
D10-Medication Adherence for Cholesterol (Statins)	PDE		Not Appealable	
D11-MTM Program Completion Rate for CMR	Part D Plan Reporting		Not Appealable	
D12-Statin Use in Persons with Diabetes (SUPD)	PDE data		Not Appealable	

Additional Comments (Please provide any additional information relevant to your request)

Request for Reconsideration for Measure C30 – Call Center – Foreign Language Interpreter and TTY Availability based on incorrect data set used to calculate star rating that included call #C0600900 received 2/9/23

For call C0600900, there was a technical issue caused by the CMS caller's deviation from protocol that ultimately caused the call to exceed the 8 minute threshold. The issue was that the CMS caller did not ask the question clearly, including a stumble at the start, and speaking unusually slowly and stating the plan name in a non-standard manner that the interpreter had trouble understanding. The English translation of the CMS caller's question asked was "are you the per.....are you the right person to answer questions about the medical advantages of.....uhhh.....Village Health.....H-M-O.....P-O-S.....C.....S-N-P?" [The dots represent pauses the CMS caller made in speaking] The total time taken to ask the question from beginning to end was 25 seconds, which demonstrates how long the pauses were. The CMS caller's phrasing of the question and the way it was asked, specifically the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. It was the additional 34 second delay caused by the question needing to be repeated that ultimately caused the call to exceed the 8 minute threshold.

For comparison purposes, we have also attached a recording of another French language interpreter availability assessment call that we received this year (C1201277 that we received on 3/24/2023). In call C1201277, the CMS caller asked the same question more clearly without the stumbling and excessively slow spelling out of the plan name (which was the exact same plan name as in call C0600900). The total time taken to ask the question was just 17 seconds and did not result in the interpreter needing to have the question repeated in order to translate. The total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 41 seconds.

For call C0600900, the total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 86 seconds – 45 seconds longer than in call C1201277 where the caller did not stumble through the question and was much clearer. The failed call missed the time cutoff by 31 seconds. Thus, were it not for the additional delay caused by the non-standard way the C0600900 CMS caller asked the question, call C0600900 would have passed and not failed. Additionally, in spite of the 25 seconds it took just to ask the standard question in call C0600900, if you exclude the additional time associated with the question having to be repeated (34 seconds), the call would have been completed within the time limit. The technical specifications for this measure C30 – Call Center – Foreign Language Interpreter and TTY Availability state that "For the interpreter availability measure to be complete, the CSR, with the interpreter's help, must be able to respond "yes" to the introductory question before the 8-minute timer expires." Time delays that are caused by the CMS caller asking the question in a non-standard way, and thus causing confusion on the part of the interpreter and the need for the call to be repeated, should not be included in the evaluation of a specific call success. Thus, we believe that this call was incorrectly included as a failure in our data and should be reversed to be counted as a completed call since the time in excess of 8 minutes was due to the CMS's caller's failure to follow established CMS protocols. At a minimum, the non-standard way the question was asked should warrant exclusion of this call from the dataset for this measure. CMS mischaracterized the call as a failure, and this data inaccuracy led to a calculation error for our performance on the C30 measure.

Additional Note
It is also worth noting that another possible contributor to the problem with call C0600900 was a technical issue with the standard question asked – specifically, that the question asked was not consistent with the standard question outlined in the Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes. Page 17 of the technical notes state that the introductory question asked by CMS callers is "are you the right person to answer questions about [Plan name's] health benefits?" However, in call C0600900, the CMS caller framed the question in a way different than what is identified in the technical notes. The caller asked "are you the right person to answer questions about the medical advantages of [Plan name]." When dealing with Medicare Advantage products, asking the question with "medical advantages" right before the Plan name can cause additional confusion for the interpreter, and was a proximate cause of call C0600900 exceeding the 8 minute time limit. Where a deviation from the published CMS protocols by CMS or its contractor is the cause of an MA plan exceeding the 8 minute threshold, it is not appropriate for CMS to penalize the MA plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1129 and form number CMS-10346 (Expires: 8/31/2024). The time required to complete this information collection is estimated to average 8 hours, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

Request for Reconsideration for Measure C30 – Call Center – Foreign Language Interpreter and TTY Availability based on incorrect data set used to calculate star rating that included call #C0600900 received 2/9/23

For call C0600900, there was a technical issue caused by the CMS caller's deviation from protocol that ultimately caused the call to exceed the 8 minute threshold. The issue was that the CMS caller did not ask the question clearly, including a stumble at the start, and speaking unusually slowly and stating the plan name in a non-standard manner that the interpreter had trouble understanding. The English translation of the CMS caller's question asked was "are you the per……are you the right person to answer questions about the medical advantages of……uhhh…..Village Health…..H-M-O……P-O-S…..C…..S-N-P?" [The dots represent pauses the CMS caller made in speaking] The total time taken to ask the question from beginning to end was 25 seconds, which demonstrates how long the pauses were. The CMS caller's phrasing of the question and the way it was asked, specifically the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. It was the additional 34 second delay caused by the question needing to be repeated that ultimately caused the call to exceed the 8 minute threshold.

For comparison purposes, we have also attached a recording of another French language interpreter availability assessment call that we received this year (C1201277 that we received on 3/24/2023). In call C1201277, the CMS caller asked the same question more clearly without the stumbling and excessively slow spelling out of the plan name (which was the exact same plan name as in call C0600900). The total time taken to ask the question was just 17 seconds and did not result in the interpreter needing to have the question repeated in order to translate. The total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 41 seconds.

For call C0600900, the total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 86 seconds – 45 seconds longer than in call C1201277 where the caller did not stumble through the question and was much clearer. The failed call missed the time cutoff by 31 seconds. Thus, were it not for the additional delay caused by the non-standard way the C0600900 CMS caller asked the question, call C0600900 would have passed and not failed. Additionally, in spite of the 25 seconds it took just to ask the standard question in call C0600900, if you exclude the additional time associated with the question having to be repeated (34 seconds), the call would have been completed within the time limit. The technical specifications for this measure C30 – Call Center – Foreign Language Interpreter and TTY Availability state that "For the interpreter availability measure to be complete, the CSR, with the interpreter's help, must be able to respond "yes" to the introductory question before the 8-minute timer expires." Time delays that are caused by the CMS caller asking the question in a non-standard way, and thus causing confusion on the part of the interpreter and the need for the call to be repeated, should not be included in the evaluation of a specific call success. Thus, we believe that this call was incorrectly included as a failure in our data and should be reversed to be counted as a completed call since the time in excess of 8 minutes was due to the CMS's caller's failure to follow established CMS protocols. At a minimum, the non-standard way the question was asked should warrant exclusion of this call from the dataset for this measure. CMS mischaracterized the call as a failure, and this data inaccuracy led to a calculation error for our performance on the C30 measure.

<u>Additional Note</u>
It is also worth noting that another possible contributor to the problem with call C0600900 was a technical issue with the standard question asked – specifically, that the question asked was not consistent with the standard question outlined in the Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes. Page 17 of the technical notes state that the introductory question asked by CMS callers is "are you the right person to answer questions about

[Plan name's] health benefits?" However, in call C0600900, the CMS caller framed the question in a way different than what is identified in the technical notes. The caller asked "are you the right person to answer questions about the medical advantages of [Plan name]." When dealing with Medicare Advantage products, asking the question with "medical advantages" right before the Plan name can cause additional confusion for the interpreter, and was a proximate cause of call C0600900 exceeding the 8 minute time limit. Where a deviation from the published CMS protocols by CMS or its contractor is the cause of an MA plan exceeding the 8 minute threshold, it is not appropriate for CMS to penalize the MA plan.

Filename: C0600900
Client: Latham & Watkins
Job ID: US1796158
Date: February 27, 2024
Transcript by TransPerfect

00:00:00.0
RECORDED VOICE 1: Thank you for calling SCAN Health Plan. In order to ensure the highest level of service, this call is recorded and/or monitored for quality and training purposes. You are not required to provide any health related information, unless used to determine enrolment eligibility. Interpreter services are available at no cost. TTY users dial 7-1-1. For English press 1. For other languages press 2.

00:00:33.2
Thank you for calling SCAN Health Plan. Your call is important to us. The call may be recorded and/or monitored for quality purposes. Please stay on the line and the next available representative will be with you shortly. If you would like to become a SCAN member, please stay on the line. If you are a SCAN member, please press 2. If you are a provider, please press 3.

[MUSIC]

00:01:08.5
RECORDED VOICE 2: Taking your medications as directed is one of the best ways to manage your health. If you take ongoing medications, ask for a three-month—

00:01:22.2
OPERATOR: Thanks for calling SCAN Health. This is Jesse. Who do I have the pleasure speaking with?

00:01:27.5
CALLER: Uhhh… French? I need French?

00:01:31.6
OPERATOR: Yes, of course. One moment please.

[MUSIC: 00:01:37 — 00:06:25]

00:06:28.6
OPERATOR: One moment please, I'm still trying to locate a translator.

[MUSIC: 00:6:52 — 00:08:05]

00:08:05.5
INTERPRETER: … the French Interpreter, everything you say will remain secret and confidential. How can I help you?

00:08:13.7
OPERATOR: I have someone on the line who speaks French. Please go ahead.

00:08:19.9

INTERPRETER: Hello. My name is [INDISCERNIBLE: 00:08:22]. I am your French interpreter. Everything you say is going to be private and confidential.

00:08:31.7
CALLER: Yes, good evening.

00:08:35.2
INTERPRETER: Good evening.

00:08:33.6
CALLER: Hello. I have, I have a question, uh… are you the per-- are you the right person to answer questions about the medical benefits of uh… Village Health HMO . . . -POS . . .C . . . -SNP?

00:09:04.3
INTERPRETER: Excuse me, ma'am. I missed that. The medical benefits of this village. Can you repeat it, please?

00:09:14.2
CALLER: Yes, that's the name of the plan. It's Village Health, then HMO . . .-POS . . .C- . . . SNP.

00:09:42.1
INTERPRETER: Are you the right person to answer questions about the plan Village plus HMO-POS C-SNP?

00:09:57.0
OPERATOR: Yes, of course. How may I assist you?

00:10:01.6
INTERPRETER: Of course. What can I do for you?

00:10:07.0
WOMAN: Thank you. This has been a test call for the Centers for Medicare and Medicaid Services. We have reached the time limit for this question. Have a good day.

00:10:16.7
OPERATOR: Thank you. You too. Thank you interpreter.

00:10:18.8
INTERPRETER: Interpreter 0629754 disconnecting. Thank you for using our service.

[00:10:29]

Call C1201277.
Latham & Watkins LLP
February 28, 2024
Transcript by TransPerfect

[00:00]

RECORDED VOICE 1: Thank you for calling Scan Health Plan. In order to ensure the highest level of service, this call is recorded and or monitored for quality and training purposes. You are not required to provide any health related information unless used to determine enrollment eligibility. Interpreter services are available at no cost. TTY users dial 701 for English press one for other languages. Press two. Thank you for calling Scan Health plan. Your call is important to us. The call may be recorded and or monitored for quality purposes. Please stay on the line and the next available representative will be with you shortly. If you would like to become a scan member, please stay on the line. If you are a scan member, please press two. If you are a provider, please press three.

[*MUSIC*]

[01:05] **RECORDED VOICE 1:** We're excited to announce that scan has been named one of the best Medicare Advantage plans in California for 2023 by us. News and world.

[01:24] **OPERATOR:** Thank you for calling Scan Health Plan. This is Tanya, who do I have the pleasure of speaking to this morning?

[01:28] **CALLER:** No, English French.

[01:31] **OPERATOR:** Of course, one moment please.

[*MUSIC*]

[03:37] **OPERATOR:** Ok Maryanne, we're both here, thank you.

[03:40] **INTERPRETER:** My name is Maryanne, I'm a translator, ID number 064487. She said: "Thank you for calling Scan Health. How can I help you?"

[03:53] **CALLER:** Hello. Are you the right person to answer questions about the medical benefits of Village Health HMO POS CSNP?

[04:16] **INTERPRETER:** Are you the right person to answer the medical advantage of [INDISCERNIBLE] Plan HMO POS CSNP.

[04:34] **OPERATOR:** Yes.

[04:38] **INTERPRETER:** Yes.

[04:41] **CALLER:** Ok.

[04:45] **CALLER:** Thank you for your time, this has been a test call on behalf of the center for Medicare and Medicaid Services, have a good day.

[04:52] **OPERATOR:** Thank you so much, both of you. Have a wonderful afternoon.

[05:00] **CALLER**: Thank you.

Call C1201277.
Latham & Watkins LLP
February 28, 2024
Transcript by TransPerfect

[05:01] **OPERATOR**: Thank you

From: CMS QBPAPPEALS
To: Michael Plumb
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)
Date: Thursday, February 22, 2024 4:56:00 PM
Attachments: Scan_CMS Response.zip
Attachment B-Informal Hearing_Form_2025_2.xlsm
QBP Decision Letter SCAN Health Plan H5425.pdf

Attached please see information related to your Request for Reconsideration.

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Monday, November 13, 2023 12:44 PM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

Great – thank you. I guess it was an issue with having multiple attachments in one e-mail. Thanks for confirming.

From: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Sent: Monday, November 13, 2023 9:34 AM
To: Michael Plumb <MPlumb@scanhealthplan.com>
Cc: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

Thank you. Confirming receipt. Yes, it plays now.

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Monday, November 13, 2023 12:31 PM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

Also strange – maybe there was an issue when attaching multiple files to the original email. I have attached the WAV file again here. Will it play for you this time?

From: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Sent: Monday, November 13, 2023 8:52 AM
To: Michael Plumb <MPlumb@scanhealthplan.com>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

Thank you Michael! This works now. I was able to open the excel file and the word files. The WAV file opens but nothing is playing for us.

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Monday, November 13, 2023 11:36 AM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

That's strange – we downloaded it from the HPMS website. Thank you for letting us know. I have attached it again, please let me know if you continue to have a problem opening the excel spreadsheet.

Were you able to open the additional files attached to our e-mail (Microsoft Word file and .WAV file)?

From: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Sent: Monday, November 13, 2023 5:07 AM
To: Michael Plumb <MPlumb@scanhealthplan.com>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

Hi Michael,

We are unable to open the excel spreadsheet. Can you please resend?

QBP Appeals Team

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Friday, November 10, 2023 12:14 AM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: QBP Reconsideration Form for SCAN Health Plan (H5425)

Attached please find SCAN Health Plan's Request for Reconsideration for MAPD contract H5425. Please note that in addition to the Excel form, we have attached two additional forms:

- An additional file (.wav format) that includes a recording of a call that we referenced in our justification for reconsideration.
- A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text

pasted into the Excel form).

Please let us know if you have any questions.

Also, to ensure CMS receipt of this request for reconsideration, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information

for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SCAN HEALTH PLAN, *Plaintiff*, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	Case No. 1:23-cv-3910-CJN

JOINT APPENDIX

VOLUME IV

Tab 25 (Pt. 1)

Adjudication Record ("A.R.")

Tab	Document Description	A.R. Page Range
25 (Pt. 1)	Reconsideration Official's Decision	SCAN-AR00445 – 00585

TAB 25
(Part 1)

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21244-1850

CENTER FOR MEDICARE

February 22, 2024

Reconsideration Determination for H5425

Dear Mr. Plumb,

SCAN Health Plan's contract H5425 requested an administrative reconsideration of its 2025 Quality Bonus Payment (QBP) determination. The request was based on the 2024 Star Ratings for the measure: Call Center – Foreign Language Interpreter and TTY Availability (C30). I reviewed the QBP determination, the evidence and findings upon which the initial determination was based, and the additional information your organization submitted. As a result of my review, CMS will not change the QBP rating for H5425. **This reconsideration decision is final and binding unless a request for an informal hearing is filed in accordance with the instructions provided in this reconsideration decision notice.**

The reason for my decision is outlined in Attachment A, "Technical Report for SCAN Health Plan H5425." Attachment A explains how the measure and values in question were calculated and provides specific information about this contract's data. The methodology for the Medicare Advantage (MA) and Part D Star Ratings is codified at §§ 422.160 - 422.166 and 423.180 - 423.186. The Medicare 2024 Part C & D Star Ratings Technical Notes, located at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html, also contain details about the methodology. Please note that, under our regulations and as discussed in Attachment A, "[a]n administrative review cannot be requested for . . . the methodology for calculating the star ratings (including the calculation of the overall star ratings)" or "the set of measures included in the star rating system." 42 CFR 422.260(c)(3)(ii). The information in Attachment A may help your organization determine whether requesting an informal hearing would be beneficial.

The administrative review process is a two-step process that includes a request for reconsideration and a request for an informal hearing on the record. This notice of the contract's reconsideration determination concludes the first step of the administrative review process. If your organization is dissatisfied with this reconsideration decision, the contract may request an informal hearing on the record to be conducted by a hearing officer designated by CMS.

The informal hearing request must pertain only to the measure and values in question that precipitated the request for reconsideration, in this case the measure: Call Center – Foreign Language Interpreter and TTY Availability (C30). The request must include a statement that describes the error(s) the contract asserts CMS made in its QBP determination and how correction of those errors could result in the organization's qualification for a higher QBP. In making the request your organization must provide clear and convincing evidence that this

reconsideration determination is incorrect. The burden is on the MA organization to prove an error was made in the calculation of its QBP. The hearing officer's decision will be final and binding on both the MA organization and CMS.

In the event that the hearing officer finds that your organization's QBP determination was incorrect, CMS will be obligated to recalculate the organization's QBP status based on that finding. The recalculation could cause your organization's QBP to become higher *or lower*. In some instances, the recalculation of the measures may not cause the Star Rating to rise above the cut off for the higher QBP Star Rating.

Pursuant to the MA organization's agreement with CMS, the deadline for providing written notice requesting an informal hearing under 42 C.F.R. § 422.260(c)(2) is five business days from the issuance of this reconsideration decision, not ten days. Request for an informal hearing on the record regarding the 2025 QBP determination is made by completing Attachment B, "Request for an Informal Hearing," and e-mailing the completed form and supporting documentation to QBPAPPEALS@cms.hhs.gov by **5:00 p.m. EST on February 29, 2024. A request for an informal hearing must be submitted by the date and time above or this reconsideration decision is final and binding.** Please ensure you receive confirmation from the mailbox that your request was received.

Any questions regarding this decision may be submitted to QBPAPPEALS@cms.hhs.gov.

Sincerely,

Jeff Grant, CMS Reconsideration Official
Deputy Director for Operations
Center for Consumer Information and Insurance Oversight

Attachment A: Technical Report for SCAN Health Plan H5425
Attachment B: Request for an Informal Hearing

Attachment B - Request for Informal Hearing

Note: The QBP administrative review process is a two-step process which includes: 1) a request for reconsideration, and 2) a request for an informal hearing after CMS has rendered its reconsideration decision. Both steps are conducted at the contract level. The burden is on the MA organization to prove that the reconsideration decision was incorrect.

Instructions: Use only the "Request for Informal Hearing" form provided with the reconsideration decision. One form must be submitted for each contract for which reconsideration is requested. Complete the identifiable information including all contact information. Please enable Macros in this form. Mark an "X" next to the measure(s) that is the basis for the Request for Informal Hearing. Do not mark any measures for which you did not request a reconsideration. Please attach full documentation that supports your request for an informal hearing on the record. Save the information, include your contract number in the filename, and e-mail the completed form along with any additional documentary evidence to be considered to QBPAPPEALS@cms.hhs.gov by the due date.

Due Date: A Request for Informal Hearing is made by completing this form and e-mailing the form to QBPAPPEALS@cms.hhs.gov by 5:00 p.m. EST on February 29, 2024. No late requests will be accepted.

Contract Number (5 character CMS assigned code):	
Contact First Name (your first name):	
Contact Last Name (your last name):	
Contact Title (your job title):	
Contact Phone Number (your phone number, include extension if necessary):	
Contact email address (your email address):	

Overall Rating	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
QBP/Overall Rating	Star Ratings		Not Appealable	

Part C Measures	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
C01-Breast Cancer Screening	HEDIS		Not Appealable	
C02-Colorectal Cancer Screening	HEDIS		Not Appealable	
C03-Annual Flu Vaccine	CAHPS		Not Appealable	
C04-Monitoring Physical Activity	HEDIS / HOS		Not Appealable	
C05-Special Needs Plan (SNP) Care Management	Part C Plan Reporting		Not Appealable	
C06-Care for Older Adults – Medication Review	HEDIS		Not Appealable	
C07-Care for Older Adults – Pain Assessment	HEDIS		Not Appealable	
C08-Osteoporosis Management in Women who had a Fracture	HEDIS		Not Appealable	
C09-Diabetes Care – Eye Exam	HEDIS		Not Appealable	
C10-Diabetes Care – Blood Sugar Controlled	HEDIS		Not Appealable	
C11-Controlling Blood Pressure	HEDIS		Not Appealable	
C12-Reducing the Risk of Falling	HEDIS / HOS		Not Appealable	
C13-Improving Bladder Control	HEDIS / HOS		Not Appealable	
C14-Medication Reconciliation Post-Discharge	HEDIS		Not Appealable	
C15-Plan All-Cause Readmissions	HEDIS		Not Appealable	
C16-Statin Therapy for Patients with Cardiovascular Disease	HEDIS		Not Appealable	
C17-Transitions of Care	HEDIS		Not Appealable	
C18-Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS		Not Appealable	
C19-Getting Needed Care	CAHPS		Not Appealable	
C20-Getting Appointments and Care Quickly	CAHPS		Not Appealable	
C21-Customer Service	CAHPS		Not Appealable	
C22-Rating of Health Care Quality	CAHPS		Not Appealable	
C23-Rating of Health Plan	CAHPS		Not Appealable	
C24-Care Coordination	CAHPS		Not Appealable	
C25-Complaints about the Health Plan	CTM		Not Appealable	
C26-Members Choosing to Leave the Plan	MBDSS		Not Appealable	
C27-Health Plan Quality Improvement	Star Ratings		Not Appealable	
C28-Plan Makes Timely Decisions about Appeals	IRE			
C29-Reviewing Appeals Decisions	IRE			
C30-Call Center – Foreign Language Interpreter and TTY Availability	Call Center			

Part D Measures	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	

D01-Call Center – Foreign Language Interpreter and TTY Availability	Call Center			
D02-Complaints about the Drug Plan	CTM	Not Applicable	Not Applicable	Not appealable, use Part C measure C25 above.
D03-Members Choosing to Leave the Plan	MEDSS	Not Applicable	Not Applicable	Not appealable, use Part C measure C26 above.
D04-Drug Plan Quality Improvement	Star Ratings		Not Appealable	
D05-Rating of Drug Plan	CAHPS		Not Appealable	
D06-Getting Needed Prescription Drugs	CAHPS		Not Appealable	
D07-MPF Price Accuracy	PDE, MPF Pricing		Not Appealable	
D08-Medication Adherence for Diabetes Medications	PDE		Not Appealable	
D09-Medication Adherence for Hypertension (RAS antagonists)	PDE		Not Appealable	
D10-Medication Adherence for Cholesterol (Statins)	PDE		Not Appealable	
D11-MTM Program Completion Rate for CMR	Part D Plan Reporting		Not Appealable	
D12-Statin Use in Persons with Diabetes (SUPD)	PDE data		Not Appealable	
Additional Comments (Please provide any additional information relevant to your request)				

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1129 and form number CMS-10346 (Expires: 8/31/2024). The time required to complete this information collection is estimated to average 8 hours, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

Technical Report for SCAN Health Plan H5425

Contents

Factual Background **2**

Regulations Governing the 2024 Part C and D Star Ratings 2

Call Center Monitoring 2

Contract's Description of the Issue: Call Center - Foreign Language Interpreter and TTY Availability (C30) **3**

CMS's Response: Call Center - Foreign Language Interpreter and TTY Availability (C30) **5**

Conclusion **7**

Appendices **8**

Factual Background

Regulations Governing the 2024 Part C and D Star Ratings

The Centers for Medicare & Medicaid Services (CMS) develops and publicly posts a 5-star rating system for Medicare Advantage (MA)/Part C and Part D plans as part of its responsibility to disseminate comparative information, including information about quality, to beneficiaries under sections 1851(d) and 1860D–1(c) of the Act and based on the collection of different types of quality data under section 1852(e) of the Act. The Part C and Part D Star Ratings system is used to determine quality bonus payment (QBP) ratings for MA plans under section 1853(o) of the Act and the amount of MA beneficiary rebates under section 1854(b) of the Act. The methodology for the Star Ratings system for the MA and Part D programs is codified at §§ 422.160 through 422.166 and 423.180 through 423.186, respectively, and we have specified the measures used in setting Star Ratings through rulemaking.

Call Center Monitoring

CMS monitors plan sponsors' Part C and Part D call centers to ensure compliance with regulatory requirements, found at 42 C.F.R. §§ 422.111(h) and 423.128(d), for providing timely and accurate information. The purpose is to measure plans' call center accessibility for current members and prospective members and to determine if the information provided to prospective members is accurate. Performance for the Part C and Part D call center measures is based on the Part C & D Call Center Monitoring Accuracy and Accessibility Study conducted from approximately February through June 2023. CMS provided notice to MA organizations and Part D sponsors, via an HPMS memo dated December 1, 2022 ("2023 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies") (see Appendix A), that the study would be conducted. In conducting the study, the CMS contractor only uses the call center phone numbers (including TTY numbers) identified by the plan in HPMS for contacting the call center.

There are two call center measures included in the Part C and D Star Ratings program – one measure focuses on Part C and the other on Part D. The measures capture Teletypewriter (TTY) Functionality[1] and Accessibility of Foreign Language Interpretation[2] when prospective members call the health and drug plan, respectively. Defined in a December 1, 2022, Health Plan Management System (HPMS) memo titled "2023 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies" (see Appendix A), and in the Medicare 2024 Part C and D Star Ratings Technical Notes[3], these measures examine the number of completed contacts with an interpreter and via TTY divided by the number of attempted contacts. To determine compliance with these requirements, CMS places outbound calls to plans' call centers.

During these calls, CMS's contracted surveyor starts and stops timers to record hold times, time for customer service representatives (CSRs) to respond to questions, and time to bring

[1] 42 C.F.R. §§ 422.111(h(1)(iv) and 423.128(d)(1)(v)
[2] 42 C.F.R. §§ 422.111(h)(1)(iii) and 423.128(d)(1)(iii)
[3] https://www.cms.gov/files/document/2024technotes20230929.pdf

interpreters into the call. Completed contact with an interpreter is when the CSR, via an interpreter, provides an affirmative response to the introductory question (e.g., "Are you the right person to answer questions about [Plan name's] health benefits?") within eight minutes, before being asked the three accuracy questions. Interpreters must be able to communicate responses in the non-primary language used by the call surveyor. Completed contact with a TTY service is when the call surveyor can connect to a live CSR and the CSR answers "yes" to the introductory question within seven minutes, before being asked three accuracy measure questions. There must be communication received back from the CSR or TTY relay operator in order to confirm that the TTY device is working properly, and a connection is made so that all parties can communicate.

The surveyor reports that a call is an "unsuccessful call" as defined by the survey methodology when the call terminates early or fails to connect without action by the surveyor or error on the surveyor end. Such calls are counted as unsuccessful calls when the plan's survey results are tabulated. On the other hand, if the call disconnects because of the surveyor's action, surveyor's error, or other failure on the surveyor's end, the surveyor does not report the call as an "unsuccessful call" and the call is not counted in the plan's survey results at all.

Contract's Description of the Issue: Call Center - Foreign Language Interpreter and TTY Availability (C30)

SCAN Health Plan (SCAN) claims that for the Part C call center measure C30, CMS used incorrect data in the calculation of the measure. They argue that one of the foreign language interpreter availability calls (C0600900) was incorrectly included in their results based on a technical issue associated with the non-standard way the CMS caller asked the standard question for their contract H5425.

SCAN states that for call C0600900, received on 2/9/2023, there was a technical issue caused by the CMS caller's deviation from protocol that caused the call to exceed the 8-minute threshold. They argue the CMS caller did not ask the question clearly, including a stumble at the start, and spoke unusually slowly and stated the plan name in a non-standard manner that the interpreter had trouble understanding. This included several pauses during the question that increased the time it took to ask the question. The total time taken to ask the question was 25 seconds, which they believe demonstrates how long the pauses were. SCAN states that the CMS caller's phrasing of the question and the way it was asked, specifically the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. They state it was the additional 34 second delay caused by the question needing to be repeated that ultimately caused the call to exceed the 8-minute threshold.

For comparison purposes, SCAN references call C1201277 which was received on 3/24/2023. SCAN states that in call C1201277, the CMS caller asked the same question more clearly without the stumbling and excessively slow spelling out of the plan name (which was the exact

same plan name as in call C0600900). The total time taken to ask the question in call C1201277 was just 17 seconds and did not result in the interpreter needing to have the question repeated to translate. The total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 41 seconds.

SCAN states that for call C0600900, the total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 86 seconds – 45 seconds longer than in call C1201277 where the caller did not stumble through the question and was much clearer. The failed call missed the time cutoff by 31 seconds. Thus, they argue were it not for the additional delay caused by the non-standard way the CMS caller asked the question in C0600900, that call would have passed and been counted as a successful call. Additionally, they state in spite of the 25 seconds it took just to ask the standard question in call C0600900, if you exclude the additional time associated with the question having to be repeated (34 seconds), the call would have been completed within the time limit.

SCAN states that time delays that are caused by the CMS caller asking the question in a non-standard way, and thus causing confusion on the part of the interpreter and the need for the question to be repeated, should not be included in the evaluation of a specific call's success. Thus, they state that this call was incorrectly included as a failure in their performance data and should be counted as a completed call since the time in excess of 8 minutes was due to the CMS's caller's failure to follow established CMS protocols. At a minimum, they argue the non-standard way the question was asked should warrant exclusion of this call from the dataset for this measure. They claim that CMS mischaracterized the call as a failure, and this data inaccuracy led to a calculation error for their performance on the C30 measure.

SCAN also states that another possible contributor to the problem with call C0600900 was a technical issue with the standard question asked – specifically, that the question asked was not consistent with the standard question outlined in the Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes. They note that page 17 of the technical notes state that the introductory question asked by CMS callers is "are you the right person to answer questions about [Plan name's] health benefits?" However, in call C0600900, the CMS caller framed the question in a way different than what is identified in the technical notes. Per SCAN, the caller asked, "are you the right person to answer questions about the medical advantages of [Plan name]." They argue when dealing with MA products, asking the question with "medical advantages" right before the Plan name can cause additional confusion for the interpreter, and was a proximate cause of call C0600900 exceeding the 8-minute time limit. SCAN states where a deviation from the published CMS protocols by CMS or its contractor is the cause of an MA plan exceeding the 8-minute threshold, it is not appropriate for CMS to penalize the MA plan.

In summary, SCAN requests that call C0600900 be reclassified as a successful call in their results. This would adjust their score for measure C30 from 95% (4 stars) to 97% (5 stars).

CMS's Response: Call Center - Foreign Language Interpreter and TTY Availability (C30)

CMS disagrees with SCAN's argument that their rating for measure C30 is incorrect. CMS has utilized a contractor to place calls to MA organizations and Part D sponsor's customer service call centers since 2009. While the methodology has undergone minor changes over the years, successful calls have always been premised on reaching a live CSR who confirms they can answer questions about the plan's Medicare benefits within a specified period of time. This is true whether the caller speaks English as a first language, is using a TTY device, or speaks a language other than English. Prior to each calendar year's monitoring, CMS releases an annual HPMS memo (see Appendix A) that describes the call center monitoring studies for the coming year; provides instructions to ensure that current, prospective, and TTY customer service call center toll-free telephone numbers are entered in the appropriate locations in HPMS; and offers best practices.

Before CMS launched the 2023 study, it first reached out to plans via the annual Call Center Monitoring HPMS memo released on December 1, 2022. Within this memo CMS provided several key points of information, including the definition of interpreter availability. The memo notes, "Interpreter availability is defined as the ability of a caller to communicate with someone and receive answers to questions in the caller's language. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits (the primary language is Spanish in Puerto Rico and English elsewhere.) A *call* is considered connected when the caller reaches a CSR. The *measure* is considered *completed* when the caller confirms that the CSR is able to answer questions about plan benefits via an interpreter (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes... The percent of completed foreign language calls (number of completed foreign language calls divided by all foreign language calls) is used for star ratings measures."[4]

SCAN has argued that the result of call C0600900 (see Appendix B for raw data related to this call) was impacted due to how the CMS caller asked the question. They claim that a technical issue occurred due to the CMS caller deviating from the standard protocol. CMS asks the same question for each call and that question is "Are you the right person to answer questions about [Plan name's] health (or prescription drug) benefits?" (see Appendix C, page 17). SCAN believes that this question was asked in a non-standard way, which caused confusion for the translator. CMS disagrees with the assertion that the caller deviated from the standard protocol and provides the table below to show exactly what was said during the call.

1	Standard version of the question when asked in English	Are you the right person to answer questions about [Plan name's] health benefits?

[4] Appendix A, page 2.

2	Standard version of the question when asked in French	Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de [Plan name]?
3	Standard version of the question translated from French back to English	Are you the right person to answer questions about health benefits of [Plan name]?
4	Exactly what the interviewer actually asked in French	Bonjour. Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de Village Health HMO POS D-SNP?
5	Exactly what the interviewer actually asked translated to English	Hello. Are you the right person to answer questions about health benefits of Village Health HMO POS D-SNP?
6	What SCAN claims the interviewer asked in French	Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de [Plan name]?
7	What SCAN claims the interviewer asked translated to English	Are you the right person to answer questions about the medical advantages of [Plan name]?

SCAN cites that it took 25 seconds for the CMS caller to ask the introductory question, which they believe shows how long the pauses were when combined with the spelling out of the plan name. SCAN believes that this was an unfairly long amount of time and that this is the reason for the call failing. The CMS callers are trained to ask the question in a conversational way, as we are assessing to see if any caller at a given point in time can receive assistance. In this instance the CMS caller asked the standard question and provided the needed information the first time. Each person has a unique style of communication and to expect that each person will speak in the exact same way is not realistic. This applies to both the CMS callers and an individual Medicare beneficiary from the general public who is calling. The purpose of these test calls is to replicate the experience prospective members would have if they called the plan's toll-free number. How prospective members ask a question will differ from call to call. SCAN has suggested that 25 seconds to ask the general question is too long, but CMS believes it is within an acceptable time frame for a conversation. (Further, 25 seconds is less than 1/16th of the available time of 8 minutes for SCAN to complete the call by providing a "yes" response to the introductory question via the interpreter.)

SCAN has stated that due to the interpreter needing the question to be restated, it added an unnecessary 34 seconds to the call, which is why it failed the 8-minute timer. SCAN's

argument ignores the fact that it took over six and a half minutes for the interpreter to join the call to begin with. SCAN chose their interpreter service and, therefore, is responsible for the performance of the interpreter service they have chosen. Had SCAN gotten an interpreter on the line only 34 seconds earlier (that is, in just under 6 minutes or *75% of the available time* to complete the call successfully on the measure), the call could have been completed successfully.

SCAN also brought up an additional French language call that they received where it took 17 seconds instead of 25 to ask the introductory question. For call C0600900 (the call being appealed) SCAN says that the time to get a translated response back was 86 seconds, or 45 seconds longer than the time it took for a different call C1201277, which SCAN characterizes as having no issue with the introductory question. CMS asked the same question on both calls, and any differences in the way they were stated is down to the individual caller, just like a non-test call would be, which is what CMS is testing (that is, how quickly a Medicare beneficiary can connect with a customer service representative to get information about the plan). With this argument, SCAN again has ignored the prolonged period that it took for the interpreter to join the call. SCAN's focus on the final seconds on a call disregards how the SCAN call center wasted the first six and a half minutes waiting for an interpreter. How SCAN elects to provide interpreters is within SCAN's control and SCAN is thus responsible for how well its chosen approach works.

SCAN has argued that a time delay caused by the CMS caller asking the introductory question in a non-standard way should not be held against the plan. CMS asks the same question on all calls. We use the same translation for each foreign language call that is placed. For the 2023 study, CMS placed 1,984 calls in French. Of those 1,761 were successful, meaning the interpreter was able to interpret a "yes" response back to the CMS caller within 8 minutes. That means that 88.76% of all French language calls were successful. Call C0600900 is the only French language call that has been questioned for this year's study around the issue of how the introductory question was asked. In addition, it should be noted that SCAN was called 13 times between Part C and Part D in French for the study, and they were successful on 11 of those calls. The only other French language call that was unsuccessful was disconnected by the plan.

Finally, SCAN stated that the translation itself could be a reason for the issue that occurred. CMS has not changed the French translation of this question for several years and there have not been other issues raised around the translation.

Conclusion

Permissible bases for requests for QBP reviews include a calculation error (miscalculation) or a data inaccuracy (incorrect data), not methodology codified in regulation. The regulation at 42 CFR § 422.260(c)(3)(ii) is clear on this. CMS consistently and appropriately administered the call center study, and calls were properly placed and scored accordingly. CMS finds no evidence that we incorrectly scored the questioned call for H5425; thus, the score for measure

C30 should not be adjusted. H5425's Star Rating for measure C30 and its QBP rating will remain unchanged.

Appendices

Appendix A – 2023 Part C and Part D Call Center Monitoring.pdf
Appendix B – Case C0600900 Raw Data.xlsx
Appendix C – Call Center Monitoring Accuracy and Accessibility Study Technical Notes 508 Technical Notes_2023_06.08.23_Final.pdf

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: December 1, 2022

TO: All Medicare Advantage Organizations (MAOs), Prescription Drug Plan Sponsors and Medicare-Medicaid Plans (MMPs) (excluding PACE contracts, cost contracts, MSA contracts, and employer-only plans)

FROM: Amy Larrick Chavez-Valdez, Director
Medicare Drug Benefit and C & D Data Group

SUBJECT: 2023 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies

The Centers for Medicare & Medicaid Services (CMS) will continue monitoring Part C and Part D call centers in 2023. This memo describes the elements CMS will monitor and explains how to prepare for the monitoring studies, including updating the Health Plan Management System (HPMS) with critical 2023 call center information **no later than December 16, 2022**.

For 2023, CMS has contracted with Insight Policy Research, and its subcontractor American Institutes for Research (AIR), to monitor the performance of plan sponsors' call centers with respect to the standards at 42 C.F.R. § 422.111(h)(1) and 42 C.F.R. § 423.128(d)(1).

The **Timeliness Study** measures Part C and Part D *current enrollee* call center telephone lines and pharmacy technical help desk telephone lines to determine **average hold times** and **disconnect rates**. This study is conducted over four consecutive weeks each quarter, during which an organization is expected to maintain an average hold time of 2 minutes or less and maintain an average disconnect rate of 5 percent or less.

Important definitions for the Timeliness Study:

1. The percentage of calls disconnected is defined as the number of calls unexpectedly dropped by the plan divided by the total number of calls made to the telephone number associated with the contract.

2. The average hold time is defined as the average time spent on hold by the caller following the interactive voice response (IVR) system, touch-tone response system, or recorded greeting and before reaching a live person.

The **Accuracy & Accessibility Study** measures Part C and Part D *prospective beneficiary* call center telephone lines to determine (1) the **availability of interpreters** for individuals, (2) teletypewriter (**TTY) functionality,** and (3) the **accuracy of plan information provided by**

customer service representatives (CSRs) in all languages. Languages tested in 2023 are unchanged from 2022 and will include English, Spanish, Cantonese, Mandarin, Vietnamese, French, and Tagalog. English will be tested as a foreign language for organizations with a service area exclusively in Puerto Rico. This study will be conducted from approximately February through June 2023.

Important definitions and exclusions for the Accuracy & Accessibility Study:

1. Interpreter availability is defined as the ability of a caller to communicate with someone and receive answers to questions in the caller's language. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) A *call* is considered connected when the caller reaches a CSR. The *measure* is considered *completed* when the caller confirms that the CSR is able to answer questions about plan benefits via an interpreter (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. CMS considers a CSR unavailable if the caller is unable to communicate with the CSR through an interpreter. The percent of completed foreign language calls (number of completed foreign language calls divided by all foreign language calls) is used for star ratings measures.

2. TTY functionality is defined as the ability of a caller using a TTY device to communicate with someone and receive answers to questions at the plan's call center directly or via a relay operator. A call is considered connected when the caller reaches a TTY/relay operator. The measure is considered *completed* when the caller confirms that the CSR is able to answer questions about plan benefits via the TTY/relay operator (before beginning the first of three general Medicare or plan-specific accuracy questions) within seven minutes of the TTY/relay operator reaching the plan. CMS considers a CSR unavailable if the caller or relay operator is unable to communicate with the CSR. The percent of completed TTY calls (the number of completed TTY calls out of all TTY calls) is used for Part C and D Star Ratings measures.

3. Contracts with *only* Special Needs Plans (SNPs) are excluded from the accuracy measure.

4. Contracts or plan benefit packages (PBPs) under marketing and enrollment sanction are excluded from the study.

In the event that an organization believes that CMS may have miscalculated its call center results based on data posted in HPMS, it may bring the relevant information to CMS' attention and ask for a review of the results. We advise organizations that they should ask for this review within 2 weeks if they do not want the data reflected in compliance actions, public reporting, or star ratings. CMS may not be able to make adjustments if issues aren't brought to its attention within 2 weeks. CMS will not revise results based on challenges to the methodology, which has been applied to all subjects of the study.

IMPORTANT ACTION: Verify 2023 Call Center Information

Compliance Officers should prepare for this monitoring effort by ensuring the accuracy of 2023 Part C and/or Part D call center telephone numbers in HPMS by **December 16, 2022**. This includes current and prospective enrollee **toll-free** beneficiary call center telephone numbers**, toll-free** pharmacy help desk numbers, and current and prospective enrollee **toll-free** TTY numbers. Telephone numbers are extracted from HPMS on a weekly basis and updated in the monitoring contractor's automated dialing software. If any of the telephone numbers change during the year, sponsors must update their telephone numbers in HPMS immediately, pursuant to 42 C.F.R. §§ 422.504(f)(2)(vii) and 423.505(f)(2)(vii). It is important that all organizations always keep these telephone numbers up-to-date in HPMS. Organizations should notify CallCenterMonitoring@cms.hhs.gov after an update is made. **If an organization achieves poor results on the measures due to calls to an inaccurate telephone numbers, the calls will not be invalidated and the results will not be negated. It is very important that accurate information is available in HPMS prior to the launch of the studies.** Use the paths outlined below to verify and/or update the telephone numbers.

Verify your pharmacy technical help desk number, which is a contract-level contact and not a bid-level contact, using the following path: HPMS home page: > Contract Management > Basic Contract Management > [select contract number] > [enter the contract number] > Contact Data > Pharmacy Technical Help Desk Contact. There are primary and secondary contacts collected in this section. The primary contact is mandatory and the secondary contact is optional. Please note that for call center monitoring purposes, we call only the primary contact.

Verify current and prospective enrollee numbers and TTY numbers through the following path: HPMS home page: > Plan Bids > Bid Submission > CY 2023 – Manage Plans > Edit Contact Data.

Follow these steps when editing contact information in the HPMS:

1. On the Select a Contract screen, enter a contract number into the field provided (Option 1) or select a contract number (Option 2). Click Next to advance to the Update and Save Data screen.

2. On the Update and Save Data screen, select a plan, and select a contact tab.

3. Edit the mailing address, telephone numbers, and e-mail address for applicable contracts.

4. After entering data for the first contact type, the user can complete data entry for other contact types under the same plan.

Notes:

- The above process to verify the accuracy of call center telephone numbers is separate from the Call Center Indicator activity that has already begun. You should have received communication from **CallCenterIndicators@insightpolicyresearch.com** in November 2022. The Call Center Indicators identify plan benefit package (PBP) phone numbers that are served by the same physical call center. This information is important as the Accuracy and Accessibility study is conducted at the call center level, with legal entities

sharing results of calls placed to a shared call center, with a limited exceptions. The Timeliness study is conducted at the phone number level. Results of calls placed to a shared phone number are shared by all legal entities utilizing that phone number, with limited exceptions. The Accuracy and Accessibility study indicators do not impact the Timeliness study. Please be aware that while phone numbers must be kept current in HPMS, the Accuracy and Accessibility study indicators cannot be updated after the Call Center Indicator collection activity is completed

- Our regulations at 42 C.F.R. §§ 422.111(h)(1) and 423.128(d)(1) require the operation of a toll-free customer call center; MMPs also have state-specific marketing guidance that requires the toll-free number. ***Even if HPMS does not denote this as a required field in your view, having toll-free numbers available is required.*** Contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028 if you require assistance.

- **All TTY numbers must be either three numeric characters or ten numeric characters and entered into HPMS.**

  Please make certain you have entered into HPMS the **TTY local telephone number** and the **TTY toll- free telephone number.** If your plan does not use a dedicated, in-house TTY device, you may enter 711 in both fields, or you may enter the toll-free ten-digit number for a specific state relay service. The toll-free TTY telephone number must be populated, as this is the telephone number we pull for the Accuracy & Accessibility Study.

  This information can be found in Chapter 1 of the CY2023 Bid User Manual (*HPMS home page > Plan Bids > Bid Submission > CY2023 > View Documentation (under "Documentation" Section) > Bid Submission User manual for Contract Year 2023*).

Tips for Success/Best Practices

Based on several years of study results, CMS provides the following tips to help improve results.

General:

- Provide basic services and information to individuals with disabilities, upon request.

- Make available all plan materials and information, including those produced or distributed by contracted providers, in alternate formats (e.g., braille, large print, audio and data CDs, and in requested alternate languages) to individuals with disabilities upon request.

We monitor thousands of plans whose IVR options are all unique. This means it is not practical or possible to train our interviewers to always make the same selection in an IVR, and we cannot program what options they should select for each plan. We train them to listen for options such as "current members," "pharmacy," or an option for those "interested in learning more about enrolling" for prospective calls, for example. When you are setting up your IVR options, please

keep this in mind. We suggest that you train your representatives to offer a warm transfer to the correct department if a caller is misdirected. You may experience more successful call outcomes if the representative offers a warm transfer, allowing us to reach a representative who can answer our question. Simply saying, "You need to call another number" or answering "no" to the introductory question, "Are you the right person to answer questions about…." will result in an unsuccessful call outcome. We call the telephone number listed in the HPMS as provided by the plan and make the most reasonable selection in the IVR, so we expect to reach a CSR who can answer questions about the plans, or at least transfer us to the correct party who can answer those questions.

HPMS Entries:

- Current, prospective, and TTY/relay services customer service call center toll-free telephone numbers must be entered in the appropriate locations in HPMS. There is a toll-free field for TTY or Telecommunications Relay Service (TRS) telephone numbers. CMS extracts the values found in the toll-free *and* alternate toll-free fields, so please make sure HPMS reflects accurate contact information and is complete in every field. If you have updates at any time during the year, please enter them into HPMS immediately. A delay in updating the telephone number(s) prior to the start of the study may result in unsuccessful calls attributed to your plan's performance. Calls of this nature cannot be negated.

Ability to Accept Calls:

- Callers to current enrollee and prospective enrollee customer service call centers need to be able to communicate with a live person when they call from 8:00 a.m. to 8:00 p.m. Messages that ask a caller to leave their telephone number are not appropriate and will not be counted as a successful call.

- CMS' monitoring reveals that our callers experience longer-than-normal hold times at the beginning of the year. Generally speaking, CMS also notes longer hold times at the beginning of a week with improvement as the week progresses. Call centers should evaluate their own needs and consider increased staffing during busier times.

- If your organization intends to implement any new technology affecting telephone systems, ensure it will not interfere with the organization's ability to accept calls, including TTY communications.

- CMS makes the following suggestions for self-monitoring your call centers on a regular basis:
    - Test every telephone number supported by the call center.
    - Pull the telephone numbers from HPMS and ensure they ring to the intended location.
    - Test by making calls from outside the organization's telephone systems. If the plan is located off the mainland, have someone place test calls from the mainland to the plan.

- Test with more than one caller at the same time.
- See TTY section below for specific TTY testing suggestions.

- CMS will occasionally solicit volunteers for abbreviated training periods prior to the beginning of an actual study launch. This is done by randomly selecting organizations to ask if they wish to volunteer. If you are launching new technology in your call center, consider joining a pilot or interviewer training session to ensure your equipment is working as expected. Contact CallCenterMonitoring@cms.hhs.gov to discuss your desire to participate in the next pilot or interviewer training session.

- **Ensure that your organization does not employ IVR logic or other functions that will block calls at certain times based solely upon the area code of the caller.** CMS generally calls from the Eastern time zone. We call regions from the Atlantic time zone to as far west as Guam. We will call you during the business standard hours of operation (8:00 a.m. to 8:00 p.m. in the time zone(s) the plan serves). If our caller cannot reach a live representative due to programming on your end, or we hear messages stating the office is closed during the required hours of operation, the call will be counted as unsuccessful.

- Carefully review your service areas to ensure you are covering the call center is open and provides services at least in accordance with standard business practices. This means that the current and prospective enrollee call centers are open minimally from **8:00 a.m. to 8:00 p.m. for all of your plans' local service areas.** Check carefully to verify your coverage for any counties that are split into two time zones or to confirm observance of daylight savings time. For example, some contracts will occasionally serve counties that are split into two time zones. Also, most of Arizona is exempt from daylight savings time. However, the Navajo Nation lands, which extend to the states of Arizona, New Mexico and Utah, observe daylight savings time. Regardless of whether two time zones are served or daylight savings time is or is not observed, call centers are required to be open minimally from 8:00 a.m.to 8:00 p.m. in all local service areas for all of its current or potential enrollees.

- **Ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu. This is important for both studies.** Every year CMS encounters plans that offer limited IVR options without a clear way to select the option to speak with a current member representative or a prospective beneficiary representative, and the IVR message cycles over and over without a live representative answering the telephone. This results in unsuccessful calls due to time-outs. Test your systems. When planning the IVR choices, ask yourself, "If I am calling to get information so I can decide if I want to enroll in this plan, is there an IVR option for me on this prospective beneficiary telephone number?"

- Ensure callers with a private number are able to connect to your plan's customer service telephone numbers.

- Train CSRs to answer the introductory question asked of them ("Are you the right person

to answer questions about…?") When we call current member customer service lines, we only ask a question intended to determine if we have reached a person who has authority to answer questions about the Medicare plan we are calling. **If the CSR insists on first knowing the caller's name, date of birth, membership ID number, or Social Security Number or refuses to answer the introductory question by stating "no," the call will be counted as an unsuccessful call unless the party transfers the call to a person who can answer "yes" in a timely manner.** Note that we only need to confirm we have reached a CSR who has authority to answer questions so we can measure the average hold time to reach a live CSR, but we do not ask any actual benefit-related questions when we call the *current member* customer service line or the pharmacy technical assistance help line.

Interpreter Availability:

- Utilize an interpretation service to identify the beneficiary's language.

- Use interpreter services personnel who are familiar with healthcare terms and Medicare benefit concepts.

- Interpreters should:
  - Adhere to generally accepted interpreter ethics principles, including confidentiality;
  - Demonstrate proficiency in speaking and understanding at least spoken English and the spoken language in need of interpretation; and
  - Interpret effectively, accurately, and impartially, both receptively and expressively, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

- Train CSRs to connect foreign-language callers with an interpreter.

- Ensure CSRs stay on the telephone when a foreign-language interpreter joins the call.

- In order to replicate a beneficiary's actual experience, CMS telephone interviewers who are testing a language other than the primary language will not make a selection in the IVR system if the instruction is only in the primary language. **Therefore, ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu.** If the IVR instruction is available in the language being tested, the test callers will make an appropriate IVR selection. For example, if the language being tested is French, *and instruction is available in French in the IVR* to select an option for French, the test caller will make that selection. (Please note that the primary language in Puerto Rico is Spanish and English elsewhere. When testing calls in Puerto Rico, English is considered a foreign language.)

- Include a note on the beneficiary's call center record that indicates his/her preferred language, if other than English, for both written and verbal communication. Record and maintain that information in a tracking system to be used in future beneficiary contacts.

- Monitor CSR calls to ensure that foreign-language calls are being handled according to the plan sponsor's policies and procedures.

- Ensure that interpreters are available within 8 minutes of the caller reaching a CSR.

- Ensure that CSRs are able to respond promptly to questions. Each accuracy question has a 7-minute timer.

TTY Functionality:

- CMS makes the following suggestions for testing in-house TTY devices:
  - Regularly test your device to ensure that it is working properly.
  - Have outside callers call in and test the system. (If in Puerto Rico, Guam, or island off the mainland, have someone on the mainland call into your TTY system to test.)
  - Have two callers from outside the system call at the same time to make sure there is no disruption on either call, calls don't get disconnected, or garbling does not occur.
  - When testing, check for garbled language on both sides of the call.
  - Whenever you make a telephone system change, retest all TTY systems.
  - If you have an outgoing message on your in-house TTY system that states to callers that if they called this number by accident, they should call the main number instead at xxx-xxx-xxxx, confirm that a TTY-recognized call will roll over to a TTY operator. This should be tested by calling from a telephone line *and* a TTY line.
  - Verify with your telecom provider that TTY calling is supported, in case there are any settings on the carrier side that need to be adjusted.
  - If using TTY Voice over Internet Protocol (VOIP), analyze network bandwidth utilization to confirm no packet loss. If there is packet loss, internet speed will need to be increased.

- If using an in-house TTY device, have a staffing plan that includes coverage for the TTY device during the hours your call center is required to operate with live CSRs.

- If using an in-house TTY device, ensure CSRs always use "GA" for "Go Ahead" after s/he has communicated his or her opening remark or other response via TTY device, so the other party knows it can now safely transmit its next thought. Failure to use "GA" may confuse beneficiaries who are familiar with TTY systems and could result in a plan hanging up on a TTY caller who has not responded, because the caller is waiting for the "GA" as clearance to respond.

- Ensure that beneficiaries using relay services can reach a CSR who has been trained on how to best communicate through a relay operator.

- Ensure that TTY services are available in languages other than English.

- Ensure that CSRs communicating to beneficiaries through relay operators are able to respond promptly to questions. By protocol, each accuracy question has a 7-minute timer.

- The decision to use 711 for the national relay operator or a different 10-digit number for a state relay operator is a business decision made by the plan. If you use a state relay operator, be certain that all callers can successfully connect on that number, regardless of the caller's area code. Our test calls will generally be placed from the Eastern time zone It is the plan's responsibility to ensure that calls from any area code can be received via their relay operator.

Information Accuracy:

- Ensure that CSRs are trained on requirements of 42 C.F.R. § 422.111(h)(1) and 42 C.F.R. § 423.128(d)(1). Review the 2023 edition of *Medicare & You* to ensure your CSRs are trained on new Part C and Part D benefit information for 2023. Consider sharing the most recent *Medicare & You* with translator service provider.

- CSRs should have specific plan benefit package (PBP) level benefit and formulary data easily available.

- Because the time is limited to 7 minutes for each of the general accuracy questions, a best practice for CSRs is to speak at a high level first and offer more detail if asked.

    - When we ask our introductory question, ("Are you the right person to answer questions about…?"), it is always best for the CSR to respond "yes" or "no," meaning yes, the CSR is the correct person to answer questions about a specific plan's benefits, or no, the CSR is not the correct person to answer questions about the plan's benefits. The CSR should then offer a "warm transfer" to the caller so that he or she may speak to the appropriate person. If the CSR responds at this high level first, it will save time, especially if the caller needs to be transferred to another party. If the CSR spends a great deal of time trying to get more information from the caller, the timer may expire, resulting in an unsuccessful call in the plan's performance.

Guidance for Providing Services to Limited English Proficient Beneficiaries

CMS reminds organizations of the HHS Office of Minority Health's (OMH) *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (*National CLAS Standards*). Originally published in 2000, an enhanced version of the *National CLAS Standards* was most recently updated by OMH in October 2018. The *National CLAS Standards* offer health and health care organizations 15 action steps for providing culturally and linguistically appropriate services (CLAS). The *National CLAS Standards* are intended to advance health equity, improve quality, and help eliminate health care disparities. The Principal Standard is to "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" and serves as the overarching goal for *National CLAS Standards'* implementation. One key area is Communication and Language Assistance,

which includes: offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services (Standard 5); informing all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing (Standard 6); ensuring the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided (Standard 7); and providing easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area (Standard 8). The *National CLAS Standards* are available at ThinkCulturalHealth.hhs.gov/clas. CMS strongly encourages sponsors to review and utilize the *National CLAS Standards* and its guidance document, *The Blueprint*. To learn how to communicate in a way that considers the cultural, health literacy, and language needs of individuals, please visit OMH's free e-learning program, *The Guide to Providing Effective Communication and Language Assistance Services*. If you have any questions about the *National CLAS Standards*, please contact AdvancingCLAS@ThinkCulturalHealth.hhs.gov.

Call Center Monitoring Reference Materials

Technical Notes/Frequently Asked Questions and Data Dictionaries for each study are stored in HPMS via links in the lower left corners of the Performance Metrics pages. Please refer to pages 2 and 3 above for the location of the studies' results. This same location is where you will find these reference materials.

If you have any questions about the 2023 call center monitoring effort, please contact the Call Center Monitoring mailbox at CallCenterMonitoring@cms.hhs.gov. Do not use secure email when communicating with this resource. **CMS will not open a secure email message.** CMS monitors thousands of plans and cannot register for secure email with each entity. We never share personally identifiable information on this project. If you need to send something securely, send an email first so we can arrange a call to discuss a mutually agreeable password for the document you wish to send.

contract_id	caseid	contract_name	organization_type	CallCenterInd	erc	cas_casestatus
H0978	C0600900	SCAN HEALTH PLAN NEVADA, INC.	Local CCP	176	294.1	294

ERC_Description	finishnote	TimeCaseStarted	TimeCaseEnded
LEP: Timeout during wait for interpreter or prior to the interpreter answering the introductory question (more than 8 minutes)	Case timed out while waiting for Interpreter	2/9/2023 20:02:10	2/9/2023 20:12:55

CaseDuration	TimeCallMade	callerhangup	HangUpBy	CallEnded	CallDuration	time_logstart
10.8	09FEB23:20:02:15		Intvw	2/9/2023 20:12:46	10.5	20:02:15

date_logstart	time_logend	date_logend	Unprofessional_Behavior_Note	Interpreter_Problem_Note	ctype	clanguage	quarter	week
02/09/2023	20:12:46	02/09/2023			5	3	1	6

phone	Assigned_ contractID	Assigned_ PlanID	PLANNAME	ORGNAME	ts0_date	ts0_time	ts1_date
1-877-916-1234	H5943	2	VillageHealth (HMO-POS C-SNP)	SCAN HEALTH PLAN	02/09/2023	20:02:15	

ts1_time	ts2_date	ts2_time	ts3_date	ts3_time	ts4_date	ts4_time	ts5_date
	02/09/2023	20:02:47	02/09/2023	20:02:47	02/09/2023	20:03:06	02/09/2023

ts5_time	ts6_date	ts6_time	ts7_date	ts7_time	TTY_Phone	IVR_TIME	HOLD_TIME	LEP_HOLDTIME
20:03:45	02/09/2023	20:11:45	02/09/2023	20:12:55		31	26	480

TTY_HOLDTIME	CASETYPEIndicator	MMP_Indicator	INDSNP	resCallCount	dayofwk	timeofday	ZIPCODE	COUNTY	STATE	QUESTION1
	C	0	1	1	4	19	90051	Los Angeles	California	0

QUESTION2	QUESTION3	ANSWER1	ANSWER2	ANSWER3	A1	O_A1M1	A2	O_A2M1	A3	O_A3M1

CCETIMEZONE	TTY_TYPE	ANSWERED	IVR1	IVR2	IVR3	IVR4	IVR5	IVR6	IVR7	IVR8
PST		1	FROM HOLD							

IVR9	IVR10	IVR11	IVRResult	HOLD	LIVE	O_LIVE2M1	O_LIVE2M2	O_LIVE2M3	EndScreen	EndScreen2
				1	1	90				

Unprofessional	INTERPRET	linesttime	lineendtime
		11	23

Medicare

Part C & D

Call Center Monitoring

Accuracy and Accessibility Study

Technical Notes

Table of Contents

DOCUMENT CHANGE LOG 2
PURPOSE 2
BACKGROUND 3
CONTACT INFORMATION 4
PERFORMANCE METRICS AVAILABILITY IN HPMS 5
UNDERSTANDING THE DATA: CALL OUTCOMES COMPARED TO MEASURE OUTCOMES 5
PERFORMANCE METRICS AS DISPLAYED IN HPMS 8
CALL CENTER MONITORING DEFINITIONS 12
HPMS DISPLAY GROUPINGS 15
RAW DATA 15
DATA DICTIONARY 15
FREQUENTLY ASKED QUESTIONS 16

Document Change Log

Previous Version	Description of Change	Revision Date
2008	Added purpose section, contact information, and expanded/clarified definitions	05/15/2016
2017	Revised call and measure outcomes and provided additional detail for performance metrics shown in HPMS for 2017, including unsuccessful calls.	3/23/2017
2019	Expanded sections for Purpose, Contact Information, and Understanding the Data. Added FAQs.	06/30/2019
2021	Revised language to match the Call Center Monitoring Memo, and expanded/clarified definitions	07/20/2021
2022	Revised based on 42 CFR 422.111(h) and 423.128(d)	06/30/2022

Purpose

This document describes the Medicare Part C and Part D Call Center Monitoring metrics for the yearly Accuracy and Accessibility Study. All results are reported at the contract level.

Background

Each year, CMS issues an annual Call Center Monitoring Memo to all Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs), Medicare Advantage-Prescription Drug Plans (MA-PDs), and Medicare-Medicaid Plans (MMPs) affected by the Call Center Monitoring studies it performs. The memo explains that the studies are for the purpose of monitoring the performance of plan sponsors' call centers with respect to the standards adopted to implement 42 C.F.R. §422.111(h)(1) and 42 C.F.R. §423.128(d)(1). The annual memo describes the study and also offers tips to help your organization be successful. The annual memo supersedes any definitions contained in this document.

In an effort to reduce the burden on plans by reducing the number of phone calls necessary for the Accuracy and Accessibility Study, CMS selects samples across *call centers* rather than basing this study on the phone number itself. In order to select these samples, we review the toll-free prospective beneficiary customer service phone numbers listed in HPMS for your Part C and Part D prospective customer service centers. CMS' monitoring contractor, Insight Policy Research, then asks the compliance officer on record in HPMS to indicate if the customer service phone numbers route into the same or different physical call centers. The monitoring contractor then determines the number of distinct physical call centers indicated by the compliance officer and notes which phone numbers route to each unique physical call center. The contractor assigns a unique call center indicator (in other words, a numerical identifier) to each call center for use in the study.

This study is conducted at the call center indicator level by calling all toll-free prospective phone numbers for the Part C call center or the Part D call center. A simple random sample method is adopted for the Accuracy and Accessibility Study where no advance knowledge of call centers' Limited English Proficiency (LEP) and TTY services or customer service representative (CSR) performance is required. There are eight different survey modes: English, Spanish, French, Vietnamese, Mandarin, Cantonese, Tagalog, and TTY. (These modes are announced each year in the annual call center monitoring memo.) English is considered the native language we are testing for all states/territories except Puerto Rico, where Spanish is tested as the native language. For interpreter availability/LEP calls, the overall sample size is first determined at the unique phone line or call center level and the sample size for each mode is then allocated. Although TTY services utilize a separate set of phone numbers, TTY is defined as one of the survey modes and it is treated like one of the languages from the sample design perspective. Therefore, TTY calls are a subset of the total sample. Since there is no TTY call center information, TTY sample size is first built at the unique TTY phone number level. For state relay phone numbers and other TTY lines that cover a large number of contracts, the sample is selected at the TTY/ LEP call center level to get sufficient coverage for these lines.
The metrics and compliance outcomes are posted in the HPMS at the conclusion of the study. The raw data, which is available by download from HPMS, show which accuracy questions were "assigned" to plans for each case/call. Each call center is assigned a numerical call center indicator which is also shown in the raw data. All plan-level results are "rolled up"and reported out to you in HPMS by contract ID.

Results are displayed for all MAOs, MA-PDs, PDPs, and MMPs. Data were collected from contracts that cover U.S. territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only direct Contract

PFFS, National PACE (Programs for the All-Inclusive Care of the Elderly), MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers. Contracts with *only* SNPs are excluded from the accuracy measure of the Accuracy and Accessibility Study. Any plan under marketing and enrollment sanction is excluded from the Accuracy and Accessibility Study until such sanction is released.

The following categories are reported within the HPMS Call Center Monitoring Part C and Part D Prospective Beneficiary Customer Support Performance Metrics sections: TTY functionality, interpreter availability/LEP, accuracy measures, and breakouts by language tested, unsuccessful calls, and Star Ratings. The TTY functionality and interpreter availability/LEP scores are combined for Star Ratings purposes but are shown in the Call Center Monitoring data only as they relate to the Accuracy and Accessibility Study. Inquiries about Star Ratings should be referred to the Part C & D Star Ratings Team.

Contact Information

The Call Center Monitoring resource mailbox can assist you with all aspects of Call Center Monitoring, including questions or concerns related to this study. Please include the contract ID, phone number on which the call was received, and specific details such as the unique call ID found in the raw data or the date and time of the call along with your question/concern. **Please do not use secure email to communicate with us.** This project never shares personally identifiable information.

If you have questions or require information about other subject areas that overlap with Call Center Monitoring, please write to those contacts directly and cc the Call Center Monitoring mailbox.

- CMS Medicare Learning Network Team: MLNMattersTeam@cms.hhs.gov
- Part C & D Star Ratings: PartCandDStarRatings@cms.hhs.gov

Performance Metrics Availability in HPMS

Detailed results (e.g., number of calls by language, number of questions answered correctly, number of completed TTY calls, etc.) will be available in the HPMS at the following paths: (https://hpms.cms.gov):

1. For Part C results, from the HPMS home page (https://hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part C Prospective Beneficiary Customer Service > [choose date range for current study] > [enter the contract number].

2. For Part D results, from the HPMS home page (https://hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part D Prospective Beneficiary Customer Service > [choose date range for current study] > [enter the contract number].

Understanding the Data: Call Outcomes Compared to Measure Outcomes

Call outcomes and measure outcomes may differ, meaning you may have a call listed in the raw data that reached a CSR, but one of the measures included in that call was not successful. To help you understand your raw data and your results, please think about the separate phases of each call as shown below:

Phase 1: Dial
Phase 2: Connect
Phase 3: Introductory Question (Interpreter Availability/LEP or TTY measure)
Phase 4: Accuracy Measure

In phase 1 *(dial)*, we download your toll-free and alternate toll-free (TTY) calling information fromHPMS. We program it, schedule it, and then dial it.

In phase 2 (*connect*), we determine if we can reach a live CSR at the plan who can assist us with our questions. Reasons for unsuccessful calls may include (1) wrong number listed in HPMS; (2) technology barrier preventing us from connecting (e.g., all circuits are busy; please check number and try again later); (3) prolonged wait times for a representative due to high call volumes at the plan; (4) center is closed at an inappropriate time; or (5) other reasons caused by the plan or the plan's phone carrier.

Whichever type of call was scheduled (TTY, interpreter availability/LEP, or native language call) will be scored as unsuccessful if we are not able to connect to a live CSR at the plan during that scheduled call or if the CSR cannot assist us with our questions or cannot forward our call to someone who can assist. (CMS provides you with a data dictionary in HPMS. The data

dictionary provides definitions for our numerical codes in the raw data. These codes explain the outcome for you.)

Once we connect to the plan, we wait in the IVR or hold queues until a CSR is available, with certain time limits. Timers allow 10 minutes each for wait times in both hold and IVR queues for non-TTY calls. If either timer expires before we reach a live CSR, the call is unsuccessful. Whichever type of call was scheduled (TTY, interpreter availability/LEP, or native language call) will be scored as unsuccessful if we are not able to reach a live CSR.

If we connect with a live CSR within the given time parameters, the call moves into phase 3 (*introductory question*), which varies depending on the type of call being made. At this point, for foreign language calls, we also test interpreter availability/LEP and ask the introductory question. We then move to phase 4 for the accuracy measure where we ask up to three accuracy questions. For TTY calls, we test TTY functionality, ask the introductory question, and then move on to the fourth phase for the accuracy measure.

For native language calls, we ask our introductory question to ensure we are speaking with a representative in the correct department and then we move into phase 4 to ask the three accuracy questions.

- For native language the *call* is connected if we reach a live representative within the permitted time.
- The *interpreter availability/LEP measure* may have a connected, complete, or unsuccessful outcome. If we are testing interpreter availability, we place the call in a foreign language and wait for the CSR to bring an interpreter to the phone to assist the CSR in answering our introductory question. We permit eight minutes for the CSR to connect to an interpreter *and answer our introductory question*. An example of an introductory question is, “Are you the right person to answer questions about [Plan name’s] health benefits?” The *call* is considered **connected** when the caller connects with the CSR. The *interpreter availability/LEP measure* is considered ***completed*** when the CSR, via an interpreter, provides an affirmative response to the introductory question (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. Alternatively, if a CSR happens to speak the foreign language we are testing, and that representative is able to answer the questions without an interpreter’s assistance, this too would count as a **completed** interpreter availability/LEP measure outcome. In order for the *interpreter availability/LEP* measure to be **complete**, there must be true communication, meaning the CSR must answer the introductory question and be able to converse in the foreign language we are testing with or without an interpreter’s assistance. For non-SNP cases, we will then move to the accuracy measure by asking the first of three accuracy questions.
- The *TTY functionality measure* may have a connected, **complete,** or unsuccessful outcome. When we test TTY functionality, we contact the plan via TTY device either directly for in- house TTY devices or via a state or national relay operator’s assistance when the plan opts to list 711 or a state relay operator’s phone number in HPMS. If we can connect to a live CSR and they answer “yes” to the introductory question (e.g., “Are you the right person to answer questions about [Plan name’s] health benefits?”) within seven minutes,the *TTY functionality measure* is **completed**.

- For non-SNP cases, we will then move to the accuracy measure by asking the first of three accuracy questions.
- The final phase for non-SNP calls is the accuracy measure. Recall that SNPs are exempt from the accuracy measure, so for SNPs, this phase is skipped. Accuracy question outcomes are defined as either having been *answered correctly* or *answered incorrectly*. Accuracy questions *not answered* due to a timer expiring are not included in the calculation of the percentage of accurately answered questions for this measure. For this reason, not answering before the seven-minute timer expires is neutral to the plan's performance.

If we are testing accuracy *in the native language*, we simply call the plan's toll-free prospective phone number and ask the CSR "Are you the right person to answer questions about…?" and wait to ensure we hear a "yes" response before we move on to the first accuracy question. English calls placed within the United States are given seven minutes to answer the introductory question. Spanish calls paced within Puerto Rico are likewise given seven minutes to answer the introductory question. (Please note that when we call plans in Puerto Rico, where Spanish is the native language, and we ask questions in English, this is considered an interpreter availability/LEP call and not a native language call, so CSRs would therefore be given eight minutes to answer the introductory question.)

For all non-SNP call types, we ask up to three plan-specific benefit questions or general Medicare questions. The contractor knows the correct answer it should receive, and their interviewer "scores" the answer received from the CSR against the expected response. In the raw data, you will see the question we asked, the expected response, and the scoring. If an incorrect answer was provided by a CSR, we record what the CSR stated during the call in the raw data. You may use the raw data to better understand your accuracy measure scores. You should also use the raw data and results from the study as a learning experience for your CSRs. CMS recommends that you review the raw data to see what questions were answered incorrectly, and then review the correct information with your staff members as a knowledge refresher opportunity.

The raw data will show outcomes for each test call placed. The raw data will include a numerical code for the call that also explains the call outcome. Please refer to the data dictionary to help you decipher the numerical call outcome codes. The data dictionary is available for download in HPMS next to the link for the Raw Data at the bottom of the performance metrics pages. In addition to the raw data, HPMS will list the unsuccessful call in the performance metrics section as well as the reason why the call was unsuccessful.

Please be aware that certain outcome codes in the raw data imply **a call is completed!**

- **Code 295** indicates the *call* was completed, meaning that the interpreter availability/LEP or TTYmeasure (phase 3) and the accuracy questions (phase 4) were completed.
- **Code 295.2 indicates an SNP call was completed,** meaning the interpreter

availability/LEP or TTY measure (phase 3) was completed**.** (SNPs do not receive accuracy questions.)

- **Code 290.x** *(where x is filled in with a number)* indicates that interpreter availability/LEP or TTY measure (phase 3) was completed, and the accuracy measure (phase 4) was *partially* completed. This means we reached a live CSR and received a response to the introduction question, but a later measure was not able to be completed for some reason. For example, code 290.7 is defined in the data dictionary as "Partial interview - CSR could not answer accuracy question in seven minutes." This means the *call* was answered by a live person and the phase 3 measure (interpreter availability/LEP, TTY functionality, or native language call) was completed. We then moved on to the phase 4 component of the call – the accuracy measure - where a separateseven-minute timer is activated for each accuracy question. In this example, a code 290.7could mean that the CSR did not answer the first, second, or third accuracy question because a timer expired, or some other problem prevented that from happening. You can review the raw data for the individual call to determine if each question was answered and, if so, whether it answered accurately or inaccurately. The raw data also shows you if and when a timer expired for an accuracy question, meaning on the first, second, or third accuracy question. Please recall that any unanswered question has a neutral impact to the plan's performance and is not cause for concern.

Performance Metrics

The performance metrics listed below correspond with column letters in the Call Center Performance Metrics tables in HPMS.

Total Number of all Monitoring Calls – This metric is the number of all monitoring calls, including interpreter availability/LEP, TTY, and native language calls.

Total Number of Completed Monitoring Calls - This metric includes the total number of completed LEP calls, completed TTY calls, and completed native language calls (codes 295, 295.2, 290.x).

All Calls - Percentage of Completed Calls out of All Calls – This metric shows the percentage of completed monitoring calls out of the total number of monitoring calls.

Unsuccessful Calls – This section shows the call weeks, which are the calendar weeks of the year when the study was active. For example, week 1 is the first week in January. This study is normally active from approximately February through June. The chart includes a count of unsuccessful calls, the total number of unsuccessful calls during the study, and a call outcome description. For example, the reader may see an outcome description that states, "TTY seven-minute HOLD." This would imply that the call interviewer was on hold for longer than seven minutes when testing TTY functionality, and therefore the call was unsuccessful, and thus the TTY measure was unsuccessful.

A call is classified as unsuccessful for any of the following reasons:

- Phone number was called but did not answer after six rings.

- Survey could not continue; Call Center disconnected call (including hanging up).
- Survey could not continue; Call Center responded in Spanish only.
- Survey could not continue; call dropped before it rang six times.
- Survey could not continue; line did not accept incoming calls.
- Survey could not continue; message stated that the target number cannot be dialed from surveyor's area code.
- Survey could not continue; phone line problems.
- Survey could not continue; reached a number that was NOT the targeted call center (due to incorrect phone number listed in HPMS).
- Survey could not continue; reached a system filtering inbound calls.
- Survey could not continue; reached Call Center voicemail.
- Survey could not continue; received a busy signal.
- Survey could not continue; technology barrier (e.g., received a computer modem/fax machine signal, beeper/pager number, etc.)
- Survey could not continue; received a message that an identification number was needed to continue.
- Survey could not continue; received a TYY device for the hearing impaired when calling via telephone.
- Survey could not continue; received message that the Call Center was closed.
- Survey could not continue; CSR refused to answer question.
- Survey could not continue; CSR insists on member name, SSN, ID etc. to continue.
- Survey could not continue; CSR tells our interviewer to call back.
- Survey could not continue: CSR unable to answer questions about Medicare/Medicaid.
- Surveyor navigated the IVR for 10 minutes and call reached time limit.
- Surveyor was in the HOLD queue for 10 minutes and then call reached limit.
- Surveyor cannot connect to TTY operator.
- Surveyor can connect to TTY operator but cannot connect to the plan.
- Survey could not continue for other reasons*.

*When the classification "*Survey could not continue for other reasons*" is used, the interviewer includes the reason in a descriptor field. Most commonly recorded reasons include:

- Disconnected number
- CSR Offers New Number to Call

Connected and Completed Calls by Language - The languages tested were: English, Spanish, French, Vietnamese, Mandarin, Cantonese, and Tagalog. HPMS displays the total number of monitoring calls, total number of connected calls, total number of completed calls,and percentage of completed calls out of all calls.

Total Number of All Interpreter Availability/LEP Monitoring Calls – The metric shows the total number of monitoring calls placed to test interpreter availability.

Total Number of Completed Interpreter Availability/LEP Calls Out of All LEP Calls – This metric shows the total number of times that an attempt to confirm interpreter availability was completed**.**

A call is considered **connected** when the caller reaches the CSR (phase2). A call is considered **complete** when establishing contact with an interpreter (or receiving assistance through a bilingual CSR), answering the introductory question (phase 3), and then beginning the first of three general Medicare or plan-specific accuracy questions (phase 4) within eight minutes of reaching a CSR. (For example, this means the introductory question was answered "yes" before moving on to the first accuracy question in the accuracy measure.) Interpreters must be able to communicate responses to the call surveyor in the callcenter's non-primary language (Spanish in Puerto Rico and English elsewhere) about the plan sponsor's Medicare benefits.

Percentage of Completed Interpreter Availability/LEP Calls Out of All LEP Calls – This metric shows the percentage of completed LEP calls out of the total number of all LEP monitoring calls.

Total Number of TTY Monitoring Calls - This metric shows the total number of monitoring calls placed to test TTY functionality.

Total Number of Completed calls to the organization TTY number - This metric shows the total number of times that an attempt to confirm TTY functionality was completed.

Completed contact using a TTY device is defined as establishing contact with and confirming that the CSR can answer questions about the plan's Medicare Part C (or Part D) benefit within seven minutes. *Remember:* A call is considered connected for TTY cases when the caller reaches the plan.

Percentage of completed calls to the organization TTY number – This metric shows the percentage of completed TTY calls out of the total number of TTY monitoring calls.

Star Ratings Calculation - The calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within eight minutes. Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within seven minutes. The formula is as shown below.

$$\frac{\#\text{ Completed TTY calls} + \#\text{ Completed LEP calls}}{\#\text{ TTY calls} + \#\text{ LEP calls}}$$

For more info on Star Ratings: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html

Accuracy - Total Number of Medicare Questions Answered – This metric shows the total number of times the Medicare accuracy questions were *answered* within seven minutes. If an

answer was not provided before the seven-minute timer expired during the monitoring call, it was not counted in this metric.

Accuracy - Total Number of Accurate Answers to all Medicare Questions – This metric shows the total number of times a CSR provided an accurate response to the accuracy question.

Accuracy - Percentage of Accurate Answers to all Medicare Questions – This metric is the percentage of times that a Medicare question was answered accurately out of the total number of Medicare questions answered.

Foreign Language Accuracy Result – This metric is the percentage of times that a Medicare question was answered accurately out of the total number of Medicare questions answered, when those questions were asked in a foreign language.

TTY Accuracy Result – This metric is the percentage of times that a Medicare question was answered accurately out of the total number of Medicare questions answered, when those questions were asked via TTY device.

Call Center Monitoring Definitions

Accuracy Questions – During the Accuracy and Accessibility Study, CMS interviewers will ask up to three accuracy questions per monitoring call placed. Each question is allotted seven minutes to determine if the CSR is able to provide an accurate and timely response to questions based upon the approved bid submission submitted into HPMS by the plan, or to a general Medicare accuracy question. The percentage of accurate responses is calculated as the number of questions answered accurately divided by the total number of *answered* questions multiplied by 100. Note: If a CSR is unable to answer the question before the timer expires, the call ends without progressing to the next accuracy question (e.g., question number 2 or 3). The effect of a timed-out call during the accuracy measure is neutral to the plan, meaning the question was not answered accurately or inaccurately and therefore is not counted in the accuracy measure performance metric.

Hold Time
During the Accuracy and Accessibility Study, the maximum hold time for waiting in an IVR or in the Hold queue is 10 minutes for non-TTY calls.

The Hold queue is defined as the time spent on hold by the interviewer following the interactive voice response (IVR) system, touch-tone response system, or recorded greeting and before reaching a live person. After 10 minutes has expired, the system closes out the case and the interviewer assigns a status code shown in the raw data.

Interpreter Availability is defined as the percent of time that a caller was able to communicate with someone and receive answers to questions in the caller's language and ask that person questions. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) A call is

considered **connected** when the caller confirms that the call connects to the CSR. The measure is considered **completed** when contact has been established with an interpreter and the introductory question has been correctly answered within eight minutes of reaching a CSR. The interviewer may also have moved on to asking the first of three general Medicare or plan- specific accuracy questions, but this is not required for consideration as a completed interpreter availability measure. The number of completed calls out of all foreign language calls is used for compliance as well as star ratings measures.

Limited English Proficiency (LEP) – The acronym LEP is used in the performance metrics section of HPMS to indicate a call made to determine interpreter availability as part of the Accuracy and Accessibility Study.

LEP Hold Time is a code used to capture the time waiting for the interpreter. Each call is allotted eight minutes for this timer.

LEP Hold time begins after reaching a live customer service representative and ends after the interviewer has confirmed that the CSR is available and able to assist in answering questions about Medicare Part C or Part D benefits.

Missing Data - When call data are not available for a contract, HPMS will display "N/A." Reasons for missing data include technical issues and other reasons for which calls cannot be made/connected.

Phone Numbers - *Prospective beneficiary customer service lines* are called for the Accuracy and Accessibility Study. Phone numbers used in the study were extracted from data provided by MAOs, MA-PDs, PDPs, and MMPs in HPMS for prospective Part C and Part D customer service lines. Customer service numbers were extracted at the plan-level (i.e., HXXXX-001 or SXXXX-001). Extracts from HPMS are performed to update phone numbers on a weekly basis throughout this study.

Calls are made to a number during the time it is supposed to be operable, which is at least 8:00 a.m. to 8:00 p.m. (according to the time zones for the regions in which they operate) for *prospective beneficiary* customer service lines. For example, if the same phone number serves plans in both New York and California, that number received calls from 8:00 a.m. in New York until 8:00 p.m. in California. The calls received are distributed throughout the interval. Statistics for any given contract typically include all calls made to phone numbers associated with the contract.

If any *beneficiary* customer service calls were made before the hour of 8:00 a.m. in the time zone of the contract's eastern-most service area or after 8:00 p.m. in the time zone of the western-most service area, they will be excluded from the analyses for that specific contract since the contractor is not expected to maintain call center operations at those times.

Connected Calls – Generally speaking, a call is considered "connected" when the study caller reaches a live person (or connects to the plan for TTY calls) in a timely manner. The measure is considered completed when that person confirms that they are able to assist the caller with questions about Medicare Part C or Part D benefits in a timely manner.

Time Data - All time data are provided in minutes and seconds in the format of MM: SS. **All monitoring calls are placed from the Columbia, Maryland area in the Eastern Time Zone.**

When reviewing the raw data, please remember to calculate the time difference between the East Coast and your plan's region(s).

TTY functionality is defined as the percent of the time a caller using a TTY device was able to communicate with someone who could answer questions either at the sponsor's call center or via relay operator. The calculation of this measure is the number of completed contacts with the CSR divided by the number of attempted contacts.
TTY Hold Time is a code used to capture the time waiting for the TTY operator. The TTY hold time is the time between reaching the plan, either via 711/state relay operator or connecting directly to a live CSR, and the time when a live CSR confirms he or she can assist with questions about Medicare Part C or Part D benefits and the confirmation was received on the tester's TTY device. The time for waiting for the TTY operator (TTY_HOLD) is seven minutes.

HPMS Display Groupings

The Accuracy and Accessibility Study displays all cumulative results for the total study in any given year. Weekly and quarterly totals are not available.

Raw Data

The raw data that supports these performance metrics is also available in HPMS in the Part C and Part D prospective beneficiary customer service performance metrics sections. Links to the raw data are displayed immediately below the performance metrics display. MAOs, MA-PDs, PDPs, and MMPs may download the data either in an Excel document for a single contract, or as a text-delimited file for all contracts under the parent organization ID.

Data Dictionary

A data dictionary is available for you to download via link in HPMS adjacent to the link for the raw data. The data dictionary provides an explanation for numerical codes shown in the raw data.

Frequently Asked Questions

Accuracy and Accessibility Study

Question: During what time of day do you place outbound monitoring calls for the Accuracy and Accessibility Study?

Answer: Calls are made to a number during the time it is supposed to be operable, which is at least 8:00 a.m. to 8:00 p.m. (according to the local time zones for the regions in which they operate) for beneficiary customer service lines. For example, if the same phone number serves plans in both New York and California, the number receives test calls from CMS from 8:00 a.m. in New York until 8:00 p.m. in California. The calls received in that interval are distributed evenly throughout the interval. Statistics for any given contract typically include all calls made to phone numbers associated with the contract.

Where multiple time zones are served by a single call center servicing multiple contract IDs, if any beneficiary customer service calls were made before the hour of 8:00 a.m. in the time zone of the contract's eastern-most service area or after 8:00 p.m. in the time zone of the western-most service area, the call will be *excluded* from the analyses for that specific contract since the contractor is not expected to maintain call center operations at those times.

Note: Prospective beneficiary customer service lines are called for the Accuracy and Accessibility Study. Phone numbers used in the study were extracted from data provided by MA organizations and Part D sponsors in HPMS for prospective Part C and Part D customer service lines. Customer service numbers were extracted at the plan-level (i.e., HXXXX-001 or SXXXX-001). Extracts from HPMS are performed to update phone numbers on a weekly basis throughout this study.

Prior to the start of this study, CMS asked MA organizations and Part D sponsors to indicate if the prospective customer service phone numbers in HPMS routed to one or more *physical call centers* so that CMS could assign a call center indicator. *This was done in an effort to minimize the call volume to Part C and Part D prospective enrollee customer service call centers.*

Question: How are call center indicators assigned?

Answer: CMS' contractor writes to the compliance officer and asks them to assign a letter (A, B, C for example) for each physically separate, distinct call center it operates. We do this late in the year prior to the study beginning the following year. The CMS contractor then further breaks down the sample by phone numbers, plan types, etc. and assigns indicators as necessary for call completion.

This process can become quite involved for large contracts that cover SNPs, non-SNPs, MMPs, and non-MMPs. If you are confused by the raw data and you are in a large contract that covers many plan types, it may be best to send specific questions to CallCenterMonitoring@cms.hhs.gov and we will assist you.

Below are some generalities about our contractor's process:

- Calls made to call center indicators that have phone numbers dedicated to SNP plans may be handled differently. If an assigned call center indicator only includes phone numbers that are dedicated to SNP plans, there is no change. If a call center indicator includes phone numbers that are dedicated to SNP plans along with phone numbers that serve both SNP and non-SNP, at least one LEP or English call is made to the SNP-dedicated phone number. Please note that a contract with ONLY SNPs is exempt from the accuracy measure and interviewers will not ask any accuracy questions on calls under these SNP-only contracts. Contracts with both SNP and non-SNP plans will be asked accuracy questions for the non-SNP plans and no accuracy questions are asked for the SNP plans. The results are rolled up to the contract level.
- Regarding how calls are applied, our contractor reviews the counties served by each plan type and the time zones served in those local service areas. (For example, some contracts will occasionally have counties that are split into two time zones. If two time zones are served, the call center is required to be open from 8 am to 8 pm in EACH local service area/time zone.) Calls are scheduled to be placed at appropriate times. The results of the calls are applied to every contract ID *within the call center indicator* that is appropriate based upon the time the call was actually placed.

To handle a big contract which normally covers all SNPs, non-SNPs, MMPs, and non-MMP plans, our contractor needs extra steps and assumptions to make sure that it can minimize the amount of calls to the plans. These assumptions are made, for example, for contracts with

1. Some phone numbers covering both SNPs and non-SNPs.
2. Some phone numbers covering either MMPs or non-MMPs.
3. Some phone numbers covering both MMPs and non-MMPs.

When a compliance office has indicated a physical call center is shared by SNP-only and non-SNP phone numbers, calls are distributed so that the SNP-only number receives at least one call a week. In this case, TTY calls are only made to non-SNP phone numbers. When a call center only uses SNP-only phone numbers, the call center can expect six calls per week, including TTY calls. We will not ask any accuracy questions for SNP plans, so the call is considered complete when an interpreter is available and answers "Yes" to our introductory question. In contrast, for non-SNP plans we will also ask accuracy questions. Consequently, SNPs which share phone numbers with non-SNPs can also share interpreter availability/LEP performance metrics with the non-SNP plan (but NOT vice versa.)

As stated previously, this can be confusing for large organizations, so let us know if you need help by sending your contract ID and your question to CallCenterMonitoring@cms.hhs.gov.

Question: Is there an average number of phone calls placed for the Accuracy and Accessibility Study?

Answer: Each year, CMS' contractor re-evaluates the number of calls needed for statistical significance in keeping with the margin of error for this study, so the examples below should only be used as an estimate of the volume of calls that could be received in any given year.

In 2023, you could expect to receive, on average, 96 calls ***to each call center indicator***. This

total comes from an average of 6 calls each week. Those 6 calls were comprised of 1 TTY test call, 2 native language calls, and 3 foreign language calls. In 2023, we placed *approximately* 96 calls to your Part C Call Center Indicator, and approximately 96 calls to your Part D Call Center Indicator, if you were a sponsor offering Part D services.

The contractor will review the information each year to determine how many calls should be placed for that year's study.

Recall that the Accuracy and Accessibility Study is conducted at the *call center* level, not the phone number level like the Timeliness Study. Our monitoring calls include the native language (Spanish in Puerto Rico; English elsewhere), TTY, and each of the six foreign languages that we test. Note that a call center indicator could have many phone lines (e.g., 35 phone lines in 2023) and each call will be to a different phone number when there is more than one number for a call center indicator. Another thing to note is that one phone line can be associated with multiple plans.

Interpreter Availability Measure

Question: When do you release the languages for testing?

Answer: We announce the languages in our annual call center monitoring memo. We typically release this in December of the year prior to the study. The memo is announced via HPMS and is emailed to compliance officers listed in HPMS for the organizations we monitor.

Question: During the Accuracy and Accessibility Study, when testing interpreter availability, if the interviewer remains on the line for more than the eight minutes allowed, before having an ability to ask for an interpreter, would this be considered an unsuccessful – or failed – call result?

Answer: For our Accuracy and Accessibility Study, when testing interpreter availability, there are separate timers for many functions. There is one for time spent in the IVR and a separate timer for the hold queue, and there is still another timer for time waiting for the interpreter to join. Once the call is answered, our interviewer identifies if he or she encountered an IVR or a live person (sometimes a call center is set up so that a live customer service representative answers the phone rather than the IVR options). Other things our interviewer could experience are whether there was a ring but no answer or some kind of auto-dialer failure. The majority of the time they encounter an IVR. Time spent in the IVR is captured in "IVR_Time" in our raw data. For all non-TTY calls, when the interviewer encounters an IVR, the plan has 10 minutes before the test call will time out if no CSR comes to the phone. If a timer expires, the call ends and the interviewer records information to capture the call failure so it will appear in the raw data. If a live CSR *does* come to the phone before those 10 minutes expire, our interviewer then selects "Live Operator" on their screen so that the raw data will capture the time when this

occurred. The second timer is what we call the "LEP_Hold" screen if we are testing interpreter availability, with LEP meaning "limited English proficiency." This is an 8-minute timer. The interpreter should connect with the CSR and assist with answering yes to our introductory question before the 8-minute LEP Hold timer goes off; if not, the call ends due to the timer failure, and this is an unsuccessful call counted toward the interpreter availability measure.

The introductory question we ask is "Are you the right person to answer questions about [Plan name's] health (or prescription drug) benefits?" We determine the question based upon which number we dialed - the Part C prospective beneficiary line or their Part D prospective beneficiary line. If the CSR, with assistance via the interpreter, is able to respond "yes," we move on to the first of three accuracy questions. If we hear "yes" before the timer expires and move to the first accuracy question, this is a complete interpreter availability measure outcome.

To answer your question directly, if an interviewer sat on the line waiting for the plan CSR for 10 minutes in the IVR or on hold but no CSR picked up the call, the call will time out and it will be counted as *an unsuccessful call.* If the CSR answers, this is a *connected call outcome*. If the CSR cannot get the interpreter on the line and have the interpreter help to answer the introductory question before the 8-minute LEP Hold timer goes off, the call is ended, and the interpreter availability measure does not have a complete result.

Question: Regarding the rule about connecting an interpreter within eight minutes, can no single transaction be longer than eight minutes, or is this an average?

Answer: No single transaction can take longer than eight minutes. If it takes longer than eight minutes for the CSR to bring the interpreter onto the line to answer our introductory question, the timer will expire, and the call will end. This results in an unsuccessful outcome. For the interpreter availability measure to be complete, the CSR, with the interpreter's help, must be able to respond "yes" to the introductory question before the 8-minute timer expires.

Question: During the interpreter availability test, is there actually a Limited English Proficient (LEP) person on the line, or do you use bilingual agents?

Answer: We use bilingual interviewers. They are fluent in the language being tested.

Question: How is the interpreter availability performance established? Must the call be connected *and* complete? We believe this to mean:

- Caller reaches a live CSR
- CSR brings an interpreter on the line, and the interpreter relays a response to the question, "Are you the right person to answer questions about…?" and
- Caller begins to ask the first benefit question within eight minutes of reaching the CSR.

Answer: For interpreter availability, we measure both connected and completed statuses. We report both results to you in HPMS at the conclusion of the study.

To explain further, if we establish contact with your CSR while speaking in a foreign language, *the call* is connected. Then we ask an introductory question (for example, "Are you the right person to answer questions about [Plan name's] health benefits?" The CSR will then bring an interpreter to the phone to assist with answering that question. Answering the introductory question with the interpreter's assistance (or having a bilingual CSR answer the introductory question in the language being tested) within eight minutes determines the outcome of the *interpreter availability measure* (i.e., a caller was able to reach someone who could speak the caller's language and ask that person questions). Once the interpreter helps the CSR answer "yes" to this introductory question, if done within eight minutes and allowing us to move on to the first accuracy (benefit) question for non-SNP plans, we have determined that your *interpreter availability measure* is ***complete***. Once we know that a yes answer has been received, we stop measuring interpreter availability and begin measuring the accuracy component by moving on to the first of three accuracy (benefit) questions, each of which is given seven minutes to answer. So, the definition we provide of needing to move on to begin the first of three accuracy questions for a complete interpreter availability status simply shows that the introductory question has been answered and we've then moved on to the next separate measure, which is accuracy. In other words, your explanation above is a correct understanding of the interpreter availability measure.

The difference between a connected call outcome and a complete interpreter availability measure is reported for you. A number of things could cause a call to go awry and not permit the interpreter availability measure to complete. For example, sometimes the interpreter joins the call and the CSR then hangs up or gets disconnected. Sometimes the interpreter joins but then the interpreter gets disconnected. If this happens, they cannot actually answer the introductory question, so interpretation did not occur and the measure is not complete. In this scenario, a CSR could have a second interpreter join and answer the introductory question. As long as that happens within eight minutes, we could still have a complete outcome.

Question: Does the outcome of the three accuracy questions have any bearing on the interpreter availability component of the survey, or do these just pertain to the accuracy measure?

Answer: The accuracy questions only pertain to the accuracy measure. They have no bearing on the interpreter availability measure. We only count questions in our accuracy scores that were asked to and answered by the CSR. If our timer expires before the CSR can answer an accuracy question, the effect is neutral to the plan because unanswered accuracy questions are not counted in the numerator or the denominator for the accuracy measure. So, if a timer expires, the call will end but please know that this has a neutral effect on the plan's performance.

TTY Functionality

Question: Do plans have to use teletypewriters for TTY functionality?

Answer: For the purpose of this study TTY can refer to either a machine (device) or IP software. Plans must provide TTY functionality, but CMS does not direct plans on how to handle the calls.

Question: Do you ask questions in foreign languages when testing TTY functionality?

Answer: The TTY measure is conducted in English only. For plans with service areas

exclusively in Puerto Rico, please be aware that we do test TTY only in English for your plans as well.

Question: If the state or national (711) relay operator for TTY is not available or accidentally drops the call, is the outcome considered unsuccessful?

Answer: Yes, the outcome would be considered unsuccessful if the state or national relay operator is not available or accidentally drops the call.

The majority of contracts opt to use the relay operator via 711 in lieu of using in-house TTY equipment, so we want to share additional information about the monitoring experience when using a relay operator. Below is a narrative describing the process.

During the call, the 711-relay operator narrates what is happening via TTY for the contractor's interviewer as they move through the call. That way, we can capture what is happening and report those metrics for each contract. Below is a description of how it works, andinstances when a failure is or is not counted against the contract.

The interviewer uses TTY IP (Internet Protocol) to call 711. There is no ring limit for TTY calls to the relay operator.

If the call does not connect to the relay operator on the first attempt or they receive a busy signal, they may log out of the TTY program, restart if needed, and make a second attempt to connect via 711. If they cannot connect via 711 on the second attempt, they also have a toll-free number for the relay operator to be used in a third attempt. If the interviewer uses the toll-free option in lieu of 711, they are trained to leave a comment in the call notes. For example, they might include this note, "Call did not go through with 711 and used 1-800-xxx-xxxx instead." If, after a third attempt, theinterviewer is not able to connect with a TTY relay operator, the inability to connect is reported and this is counted against the contract. Codes for reporting a failure to connect via TTY are available. For example, we might see code 296.19 (TTY Could Not Connect to Relay Operator) in the raw data results. Rationale: We attempt to create an authentic experience of a Medicare beneficiary trying to receive assistance via a TTY device. Our policy is to report an unsuccessfulcall if, after three attempts, we cannot connect to the relay operator. The organization should use this feedback to evaluate its business policy for use of a relay operator in lieu of an in-house TTY device.

Once our interviewer connects using TTY IP with the relay operator at 711, we give 711 the plan's toll-free Part C or Part D prospective beneficiary customer service number to dial. There is no timer activated at this point. We ask the TTY operator to confirm the number he or she is dialing. Note: If the TTY operator dials the wrong number, the monitoring contractor opts to use its "do over" option available to try again. In this scenario, the invalidated call is not counted against the plan.

The operator will narrate what's happening by replying through the TTY software, e.g., he or shemay type "ringing."

When answered, the relay operator will relay the next options: "Thank you for calling The Example Health Plan. Please hold for next representative," or relay the IVR options available. At this point, the seven-minute TTY hold timer is initiated.

The interviewer navigates through the IVR via the relay operator by telling the operator to select X in the IVR choices, or to say "representative." If the relay operator relays information to the interviewer indicating that his or her call disconnected from the health plan when making the requested selection in the IVR, the disconnected call gets coded as such and this is counted in the results in the same manner that disconnected calls are counted for non-TTY calls.

If the relay operator indicates there has been an extended hold time and asks if we wish to call back later, the interviewer will state again, "No, please hold for a live CSR." The CMS interviewer will hold until a live CSR answers or the seven-minute TTY hold timer expires. According to the Federal Communications Commission's Telecommunications Relay Service Consumer Guide, the relay operator answering or placing a call must stay with the call for a minimum of 10 minutes to avoid disruptions to the user, and relay operators must answer 85 percent of all calls within 10 seconds. If a relay operator is unwilling to hold for the duration of our seven-minute timer waiting for a live representative to answer, the outcome is beyond CMS' control and an unsuccessful call will be attributed to the plan.

If the call successfully connects with a live CSR who can respond "yes" to the introductory question ("Are you the right person to answer questions about [Plan name's] health (or prescription drug) benefits?") before the seven-minute TTY HOLD timer expires, the TTY measure is completed and the survey continues and each of the randomly generated three accuracy questions is asked. A time stamp is set on exiting the interviewer's screen so that the length of time to answer can be determined. The TTY_HOLD timer captures the time waiting for the live CSR to respond to the relay TTY operator. We then move to asking the first of three randomly generated accuracy questions. Each accuracy question has its own seven-minute timer.

If the relay operator stops responding via TTY before the introductory question is answered "yes" and relayed to us via TTY, this counts against the contract in the form of anunsuccessful TTY outcome. For example, our interviewer is communicating and types "GA" for "go ahead" to the relay operator on our TTY software and we receive no response in return. In this case, we remain on the line until the call times out. This is counted as unsuccessful in our test forTTY functionality because we have not had true communication in the process because we are still awaiting an answer to our introductory question. Our rationale behind this is that plans needsto know how members are affected when they attempt to contact their plan via a relay operator, especially if there are TTY functionality failures occurring during this process. We want plans to have this information so that they can make informed business decisions about processes that affect their membership.

Question: If the relay operator disconnected from the TTY test call, why would CMS attribute that unsuccessful result to the plan?

Answer: All organizations are free to decide if they want to use an in-house TTY device or TTY software to handle customer service calls from members or prospective members who have a hearing or speech impairment. When a plan opts to use a state or national relay service in lieu of using an in-house device, CMS considers the relay operator to be an agent of the plan. During our test calls, if *we* disconnect the line with the relay operator, we will not count the outcome of the call in the plan's performance. If the relay operator disconnects the call or refused to wait the

entire seven minutes in use for the TTY hold timer, CMS views this the same as if the plan had disconnected the call or hung up because CMS views the relay operator as an agent of the plan, by extension. If the plan disconnects from the call with the relay operator through which we are communicating, we also count the unsuccessful outcome of the TTY call in the plan's performance because the plan caused the disconnection to occur and thus the performance should reside with the plan. Please be aware that on our TTY calls, if the plan is disconnected, we will ask the relay operator if they know what happened, meaning we ask the relay operator if they know if the CSR hung up. Oftentimes, the relay operator will not know if the line was disconnected or the CSR hung up, but they are able to confirm for us that we still have an active line of communication open with the relay service and we are still able to communicate; therefore, our interviewer did not lose the connection with the relay operator. For this reason, if the plan or the relay service is the party that is no longer available on the call, the unsuccessful outcome is attributed to the plan.

Question: How should we decide if we want to use an in-house TTY device or software or a relay service?

Plan: This is a business decision for the plan to make and CMS cannot offer an opinion. Plans should weigh the pros and cons of using an in-house TTY system versus the national 711 relay service or their state relay number.

Question: Should we list 711 or the state relay operator's number in HPMS?

Answer: You may list either number in HPMS. When 711 is dialed, the call will route to the locality of where the call is originating from. Please understand that you can dial 711 to connect to certain forms of telecommunications relay services in the United States *instead of* having to remember a ten-digit telephone number for the state relay service. Dialing 711 makes it easier for travelers to use the relay service because they do not have to remember telecommunications relay service numbers in every state.

Question: Is there anything we should do to test our in-house TTY devices or software?

Answer: CMS, through its monitoring contractor, makes the following suggestions for testing in-house TTY devices or software:

- Regularly test your device to ensure that it is working properly.
- Have outside callers call in and test the system. (If in Puerto Rico, Guam, or island off the mainland, have someone on the mainland call into TTY system to test.)
- Have two callers from outside the system call at the same time to make sure there is no disruption on either call, calls don't get disconnected, or garbling does not occur.
- When testing, check for garbled language on both sides of the call.
- Whenever you make a telephone system change, retest all TTY systems.
- If you have an outgoing message on your in-house TTY system that states to callers that if they called this number by accident, they should call the main number instead at xxx-xxx-xxxx, confirm that a TTY-recognized call will roll over to a TTY operator. This should be tested by calling from a phone line *and* a TTY line.
- Verify with your telecom provider that TTY calling is supported, in case there are any

settings on the carrier side that need to be adjusted.

- If using TTY Voice over Internet Protocol (VOIP), analyze network bandwidth utilization to confirm no packet loss. If there is packet loss, internet speed will need to be increased.

Accuracy Measure

Question: If the timer expired during our accuracy question and we were not able to answer it, is the result counted against the contract's performance?

Answer: No, the effect is neutral to the contract. During the Accuracy and Accessibility Study, CMS interviewers will ask up to three accuracy questions per monitoring call placed. Each question is allotted seven minutes to determine if the CSR is able to provide an accurate and timely response to questions based upon the approved bid submission submitted into HPMS by the plan, or to general Medicare accuracy questions. The percentage of accurate responses is calculated as the number of *questions answered accurately* divided by *the total number of answered questions* x 100. ***Note: If a CSR is unable to answer the question before the timer expires, the call ends. The effect of a timed-out call is neutral to the plan, meaning the question was not answered accurately or inaccurately and therefore is not counted in the equation since a response was not received in the allotted time.***

Question: Are we permitted to answer the three accuracy questions within 21 minutes?

Answer: No. Each accuracy question has a seven-minute timer. If the first accuracy question is not answered before the seven-minute timer expires, the call ends. The second accuracy question will not be asked. Our interviewers make several calls to each plan so organizations should have sufficient opportunity to answer accuracy questions.

Question: Why is accuracy not included in the Star Ratings?

Answer: The accuracy measure results were previously part of the Star Ratings process. In the past, the majority of plans scored high ranks and that clustered the majority of plans together with similar results, so the measure itself was deemed to be not particularly helpful in differentiating one plan from another.

Question: Is the accuracy test on the actual answer provided by the plan's CSR or on the quality of the interpreter to relay the answer in the foreign language?

Answer: Two of the goals of the Accuracy and Accessibility Study, which is performed by testing interpreter availability, TTY functionality, and accuracy of the questions asked, is to determine if interpreters are available, and to determine the accuracy of responses given to prospective members. So, we would separate the interpreter availability component from this question, as it is a given that an interpreter is available in this scenario. In regard to the accuracy questions, an interpreter must be able to respond to questions accurately, so if the interpreter did not do that correctly, this must be attributed to the plan's performance. If the response to the question is not relayed correctly due to the failure of the language interpreter with whom the plan

contracted, we believe it is everyone's best interest to report that negative result back to the plan through the failure of the accuracy question being tested. Doing so helps inform the interpretation service's performance, and the plan can use that feedback for its future business decisions. We do not score or judge the interpreter's performance throughout the call – we are only looking for the correct response to the question. We would not hold the performance of the interpreter against the plan, generally speaking, so long as the response to the accuracy question is accurate. We are always happy to hear from any plan who believes a certain result may be unfair, and we are certainly willing to investigate issues that may arise, but in the instance described above, failure to respond accurately due to the failure of the interpreter is counted against the plan in the form of incorrect response to that the question being tested.

Please know that we also place calls in the native language, so your accuracy score is comprised of us asking questions in all modes – in English via TTY, in the native language (Spanish in Puerto Rico and English elsewhere), and via an interpreter when we test interpreter availability in six foreign languages.

Question: Please provide further clarity as to the timeliness metric utilized. For example, if a CSR begins providing the answer at six and a half minutes and finishes after the seven-minute limit. Does this count as untimely?

Answer: If the answer is not provided before the seven-minute mark, yes, it would be considered to have "timed out". It might help if I describe the timers to answer your question. The Limited English Proficiency (LEP) hold timer is used when waiting for an interpreter to assist the CSR with the introductory question (an eight-minute timer), the TTY HOLD timer is used when connecting via a TTY device (a seven-minute timer), and each of the three accuracy questions utilize a seven-minute timer. The interviewer has a screen that has a timer on it that counts up to 420 seconds (seven minutes x 60 seconds) or 480 second (eight minutes x 60 seconds). When that timer goes off, the interviewer does not have the ability to change the outcome of the call ending, so the answer is yes, if someone was halfway through the answer, the result would be the same as if they had not begun to answer -- the timer goes off and there is no longer an opportunity to accept the response from the CSR.

If we are determining interpreter availability, if we have not received a yes response to the introductory question before the timer goes off, that is counted as an unsuccessful interpreter availability measure.

When we have moved to the accuracy questions, if a timer goes off, that has a neutral effect on the plans, meaning we have already had a completed call for the interpreter availability component or TTY functionality score, so that would count in a good way for the plan if that portion of the test is over. If the timer goes off during the accuracy questions, this does not negatively impact the plan because it has a neutral effect. At that stage we are determining the accuracy of the answer only. If the timer goes off before an answer was provided, we show a "time out" in the raw data. The call will end, but the result of the timer going off during an accuracy question is simply that the question was not answered. This is not counted as unsuccessful or inaccurate, in other words.

Question: Are the accuracy questions that were used in prior years published and available? I would like to pass them along to the Member Services staff to be used in training.

Answer: No, they are not published or available. CMS cannot provide them to anyone. At the conclusion of this study, you will receive the questions, the expected responses, and your actual study results. These results are stored in HPMS for you to download.

CMS emphasizes that CSRs will be assisted if they are trained on plan-specific questions (For example, "What is my copay or coinsurance for a certain service?" and "Is a certain drug on the formulary?"). It may also help if CSRs are familiar with information in the latest version of *Medicare & You*, which is available here at the following link:
https://www.medicare.gov/medicare-and-you/medicare-and-you.html

Question: We are a plan with both SNPs and non-SNPs. Our SNPs receive calls that ask only your introductory question and nothing more. Why do you do this?

Answer: SNPs are exempt from the accuracy measure, so we do not ask accuracy questions. The main purpose of the Accuracy and Accessibility Study is to determine if a plan is capable of bringing an interpreter to the phone to assist, and to test if the plan can communicatewith a "prospective enrollee beneficiary" (CMS' contractor in this case) via TTY device. It is theresults of these two measures from which the Part C and Part D Star Ratings are derived. When we call in a foreign language or via TTY device, the "main focus" of the study is underway so we can determine if the plan was able to communicate with the caller. We ask the introductory question as a means of determining if the interpreter can join the line, in other words, or the CSR can communicate via TTY device or with the 711 relay service. Because contracts with *only SNPs* are excluded from the accuracy measure (which is not part of the Star Ratings), we have no need to ask any more questions.

Calls placed in English that ask only our introductory question are used for the Timeliness Study, where we are measuring the average hold time and disconnect rates, but they are also placed during the Accuracy and Accessibility Study. To add some historical perspective on the issue of contracts with only SNPs versus those contracts with both non-SNPs and SNPs, in years past we did not include contracts with only SNPs in our Accuracy and Accessibility Study. Those contracts asked CMS to include them so that they were a part of the data collection for Star Ratings purposes, so we added SNP-only contracts back into this study to satisfy the collection of information for Star Ratings. Because contracts with only SNPs are excluded from the accuracy questions, the introductory question is all that we ask.

We test English language calls across all studies as a first step to confirming that sponsor call center representatives are accessible and can be reached in a timely manner. Then, in addition to English language calls we test for interpreter availability and TTY service during the Accuracy and Accessibility Study for the reasons stated above. Statistically, if we did not test English during the Accuracy and Accessibility Study, we would need to make significantly more interpreter and TTY calls, thus increasing the burden on call centers to obtain information that is part of the English language subset. English is a baseline measurement and although we do not take compliance actions, we do use and analyze the data.

Accuracy and Accessibility Study Raw Data

Question: Where do I find raw data for the Accuracy and Accessibility Study?

Answer: The raw data is available to you in HPMS under the performance metrics sections. This is new functionality we added to make your experience a little easier. Previously you would have requested the raw data from the Call Center Monitoring mailbox; now you can download it yourself.

For the Accuracy and Accessibility Study, you can find detailed results for your contract in HPMS by following the paths below:

1. For Part C results, from the HPMS home page (https://hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part C Prospective Beneficiary Customer Service > [choose date of study] > [enter the contract number].

2. For Part D results, from the HPMS home page (https://hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part D Prospective Beneficiary Customer Service > [choose date of study] > [enter the contract number].

Raw Data supporting the Part C and Part D performance metrics are available to you in HPMS in a link immediately below the performance metrics for the selected contract under Part C and Part D. Please access the link entitled "Raw Data for Xxxxx," with the variable being the contract ID you selected. This is available to you for a single contract as an Excel download. Also available for your convenience is a link entitled "Raw Data for All Contracts." This link will provide a download of all raw data to which you are entitled under your parent organization identification code. The multiple-contract data are available to you in a text-delimited file format. You may use this file to import into Excel, Access, or some other database product.

You will also find a link to an Excel document entitled, "Data Dictionary for Raw Data." This is a data dictionary that explains the numerical codes used within the raw data. The data dictionary also contains all of the questions asked during the Accuracy and Accessibility Study and the numerical coding that explains the answer received by our interviewers.

In addition to the above resources, CMS provided a link for you to Technical Notes for the Accuracy and Accessibility Study.

Question: How are completed and unsuccessful calls identified in the call level data? When reviewing the raw data, we are unclear on how a completed TTY or interpreter availability call is identified in the call level data. We had assumed that ERC=295 (Reached CSR/TTY/Interviewer - completed questions) identified the completed calls. However, one call has an ERC code = 290.7 (Partial interview - CSR could not answer question in seven minutes) so we interpreted that as an unsuccessful call. Is that correct?

Answer: When downloading your raw data from HPMS, you should also see a link to a data dictionary for each study just to the left of the raw data link. Please be aware that the Timeliness

Study (current enrollees) uses one dictionary, while the Accuracy and Accessibility Study (prospective enrollees) uses a different dictionary. If you ever need these, simply download from HPMS at the same time you download the raw data.

In the raw data, look for the "ERC Code" and use the dictionary to decipher the numerical codes. Both ERC = 290.X and 295 would be counted as completed calls, because the first purpose of this study is that the contracts can provide interpreters and TTY functionality – and the second purpose is to test accuracy. Both 290 and 295 codes represent the situation that our interviewer has already talked to interpreters and received the answer to the introductory question. As a result, the difference between codes 290 and 295 is just that when we ask accuracy questions, some unexpected situations can occur (such as the timer expiring before the accuracy question is answered, which is neutral to the plan). If all three accuracy questions are asked, the call will be coded as 295 (smooth completion of all parts of the call.) If something happened such as timeout or a disconnection, we will code the call as 290.X (dot X would tell us in detail what happened when asking those accuracy questions.) However, this 290 code will not hurt the plan in regard to LEP and TTY functionality scores. In addition, if something happens when asking an accuracy question (an example would be the question is not actually answered), the question will not be counted in either the accuracy, so the effect is neutral to the plan: the CSR neither answered correctly nor incorrectly.

Because the main purpose of this study is the availability of interpreters and functionality of TTY, any situations that happened after a plan already completed the availability/functionality will not hurt the plan from those perspectives. Subsequently, the code 290 is a code for a completed call with some problems that would benefit the plans to know how to improve when answering questions in the future. On the other hand, the code also tells us that at least the plan already fulfilled the minimum requirement of interpreter availability and TTY functionality.

Question: In reviewing the raw data for a prior Accuracy and Accessibly Study result, we are noticing that there is variation within the Part C rates for three of our plans, for which calls are serviced at the same call center. Because the Accuracy and Accessibility Survey is measured at the call center level, doesn't that indicate that plans with calls serviced at the same call center would receive the same rate? Would you be able to explain the variation in the rates?

Contract ID	Plan Name	Part C Rate
HXX A	Example Plan 1	94%
HXX B	Example Plan 2	94%
HXX C	Example Plan 3	92%

Answer: You are correct that this study is conducted at the call center level, unlike the Timeliness Study which is conducted at the phone number level. First, the study is based at the call center level, so we first refer to what the compliance officer told us before the study in our response for call center indicators. To explain, we ask the Compliance Officer to tell us which lines route into separate and distinct physical call centers. So, please understand that your response to that inquiry determines how many call centers are used when testing. However, there

are other considerations that will result in variation of results when applied at the contract level. For example, SNPs are not asked the accuracy questions. Non-SNPs *are* asked accuracy questions. Results are rolled up to the contract level. So, if you have a contract with ONLY SNPs, the contract will not have accuracy results. If you have multiple contracts using the same call center indicator where some contracts are SNP-only and some are a mixture of SNP and non-SNP, you will not see uniform results for the accuracy measure.

Other considerations are the counties served by the plans and those time zones they serve. I mention this because we schedule our outgoing test calls at appropriate times based upon the time zones served by those plans. To minimize burden on the call centers, we attribute the results of those calls to contracts within the call center indicator, but the results are only rolled up to the contract level *when appropriate to do so*, meaning one should not expect to see uniform rates simply because the same call center is used. Let's say your call center covers 3 time zones, and you have 1 contract with plans under it that serve all 3 time zones. In that case, all call results would be attributed to that one contract. If you have a separate contract that only covers the Eastern Time Zone, then the results from calls made from 8:00 am to 8:00 pm in Eastern Time ***only*** would be included in that contract's performance.

General Questions

Question: Who do I contact if I have questions?

Answer: If your questions are related to our call center monitoring studies, send an email with your contract ID, date of call, time of call, and include the phone number on which the call was received, if possible, to CallCenterMonitoring@cms.hhs.gov. Please do NOT send your questions via secure email. We never share personally identifiable information on this project. We monitor thousands of plans and hundreds of contracts and we do not have the resources to maintain separate registrations for all of these contracts. Thank you for your understanding.

If your questions are related specifically to Star Ratings, send your question to PartCandDStarRatings@cms.hhs.gov.

If your question is related to call center performance metrics that fed into your Star Rating, and you are not sure which team to consult, send an email to both resource mailboxes and we will work together to answer your question.

Question: Please confirm how IVR menu choices are handled when monitoring calls are made. When the menu includes an option for member services, is this the option that will be chosen for the monitoring? In other words, they won't select options such as Behavioral Health crisis lines, provider lines or nurse lines. Is that correct?

Answer: For the Accuracy and Accessibility Study, our telephone interviewers will make an IVR/menu selection for prospective members whenever that is an available option in your IVR, *and it is an appropriate choice for the type of call we are placing*. For example, if we are placing a native language call, we call your prospective phone number and listen to the options. As long as you include a choice for prospective members, sales, or for more information about the plan in your IVR call tree, we'll make that selection. We would not make selections for behavioral health lines, nurse lines, crisis lines, or other such choices. Our callers make appropriate IVR selections whenever possible, except as described below.

If the correct IVR option is not immediately obvious to our interviewers, no IVR selection will be made. For this reason, ensure your phone systems will default to a live customer service representative if no IVR option is selected or no voice command is given.

Finally, when testing interpreter availability, our interviewers are simulating the experience of a non-English-speaking caller, so if IVR instructions are not available in the language we are testing, we do not make an IVR selection because a non-English-speaking caller could not understand what is being said and could not make that IVR selection. For this reason, ensure your phone systems will default to a live customer service representative if no IVR selection is made or voice command given.

Question: We found a call coded as 297.12 in our raw data. This disposition code says, "Neither Call Center Contact nor Ring/No Answer." Why are you counting this call against our plan's performance if you didn't contact us?

Answer: CMS' duplicate raw data lists the disposition codes from the calls we make in our call center monitoring studies (see data dictionaries that explain those codes for each study). Code 297.12 is one of the codes we use when we are unable to connect to a plan. This code is used for situations like receiving a message of "all circuits are busy" or a fast-busy signal. Our contractor has a system in place that requires their survey callers to make a second attempt *for any disposition where we cannot connect to the plan*, such as 297.12. The system will not allow the caller to record the information of "Neither Call Center Contact nor Ring/No Answer" unless a second attempt has been made to connect to the plan. Only one outcome is counted "against" the plan, but two attempts are made for every call in this scenario. The call outcome is included in the performance metrics and duplicated raw data so that the compliance officer can see the outcome of those two attempted calls/1 unsuccessful call disposition for a contract. We pass along that data so the compliance officer can understand how a beneficiary would have been impacted by the inability to connect to the plan on the same date and time.

CMS's contractor has investigated to rule out any phone equipment failures, employee error, or an issue on the part of its phone carrier before the results are issued to you. CMS is not able to offer an opinion about a call disposition of no plan contact other than it could have been a phone carrier's inability to transfer the call to the call center. The plan may check with their phone carrier to determine if there were any outages during the date and time in question. If a phone carrier caused the call not to transfer to the plan, the same outcome would happen to a real prospective beneficiary attempting to call the plan, so the disposition is included, and the information is reported out with the contract's performance metrics and duplicated raw data. This is longstanding practice that meets the expectations of the study's design.

Question: Our contracts under our parent organization share a phone number. Why are the results different for one or more of our contracts?

Answer: In a situation like the one above, it is best for you to send the specific details of your question to CallCenterMonitoring@cms.hhs.gov. We will research the issue with our contractor. Things to consider are: (1) the timeliness study is based upon the phone number. The Accuracy and Accessibility Study is conducted at the *call center level.* All share results *at the contract level* but (1) One or more contracts might have been under sanction during the Accuracy and Accessibility Study and therefore would have been excluded. (2) The plan sponsor might have

changed the phone number in HPMS at some point during the study. Our contractor tracks this and can tell us when the change was made. (3) Some functions of studies do not apply to all situations. For example, contracts with *only* SNPs are excluded from the accuracy measure in the Accuracy and Accessibility Study. (4) Contracts under one parent organization may vary, especially based upon their service areas. For example, one contract may serve only the Eastern Time Zone while another contract may serve Eastern and Central Time Zones. This would mean that each could be called the same number of hours (from 8:00 am to 8:00 pm in their local service areas), but those times would be different and thus the results applicable to a certain contract may be different. (5) The compliance officer may have told us that the phone numbers route to physically distinct call centers for the Accuracy and Accessibility Study.

Question: Our compliance officer sees a compliance action in the Compliance Activity Module in HPMS, but she never received the letter herself. Is this letter valid?

Answer: Please send the specifics of your inquiry to CallCenterMonitoring@cms.hhs.gov. We will be happy to research the Compliance Activity Module and our records to determine when the letter was issued to the compliance officer. Perhaps the email notification went to a spam or junk folder? The party questioning this, could also check the HPMS performance metrics sectionto determine if the non-compliant values match what is in the letter. Aside from that, we can offer the compliance officer the suggestion that he or she determine:

- Is the email address correct in HPMS? (The CAM auto populates letters with whatever email address is available in HPMS, so make sure HPMS is accurate.)
- Add HPMS@cms.hhs.gov in his or her contacts list so the emails do not go to the junk folder; and
- Make certain the IT system he or she uses isn't blocking the email addressHPMS@cms.hhs.gov.

Question: I'm having a hard time downloading the raw data from HPMS. Can you send it to me?

Answer: Please contact the HPMS help desk at 1-800-220-2028 or hpms@cms.hhs.gov. The HPMS Team at CMS has asked that we refer folks to the HPMS help desk whenever problems occur so that they can learn what is causing the problem and what they need to do to fix it. If this does not resolve the problem, please write to us at CallCenterMonitoring@cms.hhs.gov and tell us the contract ID, the study for which you need the raw data, and the time period for that study.

Question: Our call center received a CMS test call after our center closed. We serve only the Eastern Time Zone, and we are open from 8:00 a.m. to 8:00 p.m. Your test call came in at 8:15 p.m. Why did this happen, and will the result be counted against us?

Answer: First, be sure to adjust the timing of the call in the raw data to your time zone. For the Accuracy and Accessibility Study, we call from the Eastern Time Zone. You'll need to adjust the time accordingly if your call center is located in another time zone. If the time zone is not a factor and the call was truly placed outside of 8:00 a.m. to 8:00 p.m. in your region, CMS can invalidate the call and the call's outcome will NOT be counted against your organization.

The explanation for this is our contractor schedules calls during a certain block of time. The

interviewers work through the calls scheduled one at a time. If the interviewer falls behind on their schedule due to earlier calls having longer-than-expected wait times or other issues, the auto dialer pulls up the call and dials it, and occasionally this inadvertently happens after the scheduled block of time. Please know that we do have a quality assurance process on the "back end" of the study that reviews the service areas, expected hours of operation, and times calls were placed. If any call was placed later than expected hours of operation for your call center, the call is removed from your performance metrics and the duplicated raw data we provide to you before we share the results with you. We attempt to catch them all, but if we missed one, please let us know.

We try to minimize this from happening so that we do not take up your customer service representatives' time and resources – or our resources -- but it does occasionally happen. We are implementing a way to move these calls that are scheduled but not yet placed to the following day to avoid this problem. If you ever have questions about this, be sure to let us know at CallCenterMonitoring@cms.hhs.gov. We will be happy to research the call and confirm that it gets invalidated in your results.

Question: The upcoming Christmas and New Year's Day holiday falls on a Sunday. One of my plan's will observe the holidays on the Mondays after (12/26 and 1/2). Are they permitted to use alternative technologies on these two days?

Answer: They are permitted to use alternative technologies on Thanksgiving Day and Christmas Day only, per 42 CFR §§ 422.111(h)(1)(i), 423.128(d)(1)(i). This means they will have to support their call centers on December 26 and January 2.

Note: MMPs negotiate their holiday call center coverage. MMPs holiday coverage is dictated by their state-specific marketing guidance.

Question: How long must we retain the recordings of call center calls?

Answer: Though it is not a requirement of CMS to record a phone call, if an organization chooses to record calls then those recordings would be considered a record and would be required to comply with 42 CFR 422.504.

Question: I'd like to send you a recording of a call. How can I do that?

Answer: If you can, please convert the software to .mp3 or .wav format and put it in a compressed zip file format to email to CMS. To compress the file, highlight the file, right click with your mouse, and choose "send to a compressed file." Once compressed, please email it to CallCenterMonitoring@cms.hhs.gov along with the contract ID, the phone number on which the call was received, the date and time of the call, and the details of your request. CMS uses VLC software for recording playback. This software can read several formats including 3GP, ASF, AVI, DVR-MS, FLV, Matroska (MKV), MIDI, QuickTime File Format, MP4, Ogg, OGM, WAV, MPEG-2 (ES, PS, TS, PVA, MP3), AIFF, Raw audio, Raw DV, MXF, VOB, RM, DVD-Video, VCD, SVCD, CD Audio, DVB.

Please remember to send this via regular email and not secure email. This project never shares personally identifiable information, so secure email for a CMS test call should not be necessary.

Question: We created a contingency plan in the unlikely event all systems or phones go down. We know ideally when it comes to the test calls and member experience, we never want this to happen, but we want to be prepared for all circumstances. Does CMS have guidance or best practices if an outage like this occurs? We can play a cloud message letting callers know they can call back and would accordingly self-report it to CMS, but what happens if a test call comes in? Would we fail it if we had a cloud message and self-reported it to CMS?

Answer: In regard to contingency plans and guidance, Part D sponsors and MAOs are required to have operational continuity plans in place. These requirements are described at 42 C.F.R §422.504(o) and 42 C.F.R §423.505(p). The plans for continuity of operations must include the operation of call center customer services. Therefore, if call center operations cease temporarily due to an emergency situation or disaster declaration (or as stated above due to phone outages), the MAO or Part D sponsor should implement their continuity plan. MAO/sponsor continuity plans should include contingency plans to maintain operations or if unable, to restore call center operation within 72 hours.

CMS does not have a written best practice to share, ideally sponsors should have an alternate call center to which calls could be directed. One example used by several sponsors is an auto forward to the pharmacy technical assistance call center for issues relating to prescription drugs, pharmacy billing questions, etc. To be clear, there is no specific requirement for this, and it is only offered as an example. That said, hypothetically, the calls as described *would be* non-compliant and scored as unsuccessful attempts if our test calls reach a message asking the party to call back, due to the requirement that call centers must be open during required hours of operation. This is true even if the closure was self-reported. Again, hypothetically, inappropriate call center closures may result in compliance action. Your plan to alert CMS in such an unexpected event is a good one. CMS suggests that MAOs, MA-PDs, PDPs, and MMPs self-disclose any call center closures – whether related to declarations of emergency or not -- to the assigned CMS Regional Office Account Manager. Adding CallCenterMonitoring@cms.hhs.gov as a cc would be helpful to us. Since 2006, CMS has consistently advised Part D sponsors and MAOs to report voluntarily to CMS any instances of program non-compliance that they discover on their own. As CMS staff have stated in numerous presentations to industry, we look more favorably on instances of non-compliance when it is self-reported rather than through other means, such as beneficiary complaints, complaints from competing contractors, audits, or our own data analysis. That is, CMS believes that self-reporting can be seen as evidence of an effective compliance program, indicating that while some non-compliance has occurred, the Part D sponsor or MAO has capable management and oversight in place exercising effective control over the organization.

Question: How was compliance determined for the 2023 Accuracy and Accessibility Study?

Answer: Interpreter Availability was tested to determine if the services were compliant with 42 C.F.R. §§ 422.111(h)(1)(iii) and 423.128(d)(1)(iii), which require interpreters to be available for 80 percent of incoming calls requiring an interpreter within 8 minutes. TTY functionality was tested to determine if services were complaint with 42 C.F.R. §§ 422.111(h)(1)(iv) and 423.128(d)(1)(iv), which require 80 percent of incoming calls requiring TTY services to be connected to a TTY operator within 7 minutes. Accuracy was tested to determine if the services were compliant with 42 C.F.R. §§ 422.2262(a)(1)(i) and 423.2262(a)(1)(i), which requires MA organizations and Part D sponsors not to provide information that is inaccurate or misleading.

For 2023, we determined the accuracy compliance threshold to be 90 percent. MA organizations and Part D sponsors with accuracy results below 90 percent are outliers and per 42 C.F.R. §§ 422.504(m)(2) and 423.505(n)(2), CMS may determine that an MA Organization or Part D sponsor is out of compliance when its performance in fulfilling requirements represents an outlier relative to the performance of other organizations.

Medicare 2024 Part C & D Star Ratings Technical Notes

Updated – 12/13/2023

Document Change Log

Previous Version	Description of Change	Revision Date
09/29/2023	Corrected reopening decision deadline in the data source description for C29 in Measure Details section.	11/08/2023
09/29/2023	Updated 2024 measure IDs for display measures in Attachment J.	11/08/2023

OMB Approved Data Sources

The data collected for the Part C & D Star Ratings come from a variety of different data sources approved under the following Office of Management and Budget (OMB) Paperwork Reduction Act numbers:

Data Source	OMB Number
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys	0938-0732
Health Outcomes Survey (HOS)	0938-0701
Healthcare Effectiveness Data and Information Set (HEDIS)	0938-1028
Part C Reporting Requirements	0938-1054
Part D Reporting Requirements	0938-0992
Data Validation of Part C/D Reporting Requirements data	0938-1115

Table of Contents

DOCUMENT CHANGE LOG I
OMB APPROVED DATA SOURCES I
INTRODUCTION 9
DIFFERENCES BETWEEN THE 2023 STAR RATINGS AND 2024 STAR RATINGS 9
HEALTH/DRUG ORGANIZATION TYPES INCLUDED IN THE STAR RATINGS 10
Table 1: Contract Year 2024 Organization Types Reported in the 2024 Star Ratings 11
THE STAR RATINGS FRAMEWORK 11
Figure 1: The Four Levels of Star Ratings 12
Table 2: 5-Star Scale 12
Table 3: Relation of 2024 Organization Types to Contract Types and Highest Rating in the 2024 Star Ratings 12
SOURCES OF THE STAR RATINGS MEASURE DATA 13
Figure 2: The Four Categories of Data Sources 13
IMPROVEMENT MEASURES 13
Table 4: Minimum Number of Measure Scores Required for an Improvement Measure Rating by Contract Type 14
CONTRACT ENROLLMENT DATA 14
HANDLING OF BIASED, ERRONEOUS, AND/OR NOT REPORTABLE (NR) DATA 14
DATA HANDLING OF MEASURES FOR CONTRACTS AFFECTED BY A MAJOR DISASTER 15
METHODOLOGY FOR ASSIGNING STARS TO THE PART C AND PART D MEASURES 17
A. Clustering 17
B. Relative Distribution and Significance Testing (CAHPS) 18
METHODOLOGY FOR CALCULATING STARS AT THE DOMAIN LEVEL 18
Table 5: Minimum Number of Rated Measures Required for a Domain Rating by Contract Type 19
SUMMARY AND OVERALL RATINGS: WEIGHTING OF MEASURES 19
METHODOLOGY FOR CALCULATING PART C AND PART D SUMMARY RATINGS 19
Table 6: Minimum Number of Rated Measures Required for Part C and Part D Ratings by Contract Type 20
METHODOLOGY FOR CALCULATING THE OVERALL MA-PD RATING 20
Table 7: Minimum Number of Rated Measures Required for an Overall Rating by Contract Type 21
COMPLETING THE SUMMARY AND OVERALL RATING CALCULATIONS 21
APPLYING THE IMPROVEMENT MEASURE(S) 21
APPLYING THE REWARD FACTOR 22
Table 8: Performance Summary Thresholds 23
Table 9: Variance Thresholds 23
CATEGORICAL ADJUSTMENT INDEX (CAI) 23
Table 10: Categorization of Contract's Members into LIS/DE Initial Groups for the Overall Rating 25
Table 11: Categorization of Contract's Members into Disability Quintiles for the Overall Rating 25
Table 12: Final Adjustment Categories and CAI Values for the Overall Rating 26
Table 13: Categorization of Contract's Members into LIS/DE Initial Groups for the Part C Summary 26
Table 14: Categorization of Contract's Members into Disability Quintiles for the Part C Summary 27
Table 15: Final Adjustment Categories and CAI Values for the Part C Summary 27
Table 16: Categorization of Contract's Members into LIS/DE Initial Groups for the MA-PD Part D Summary 27

Table 17: Categorization of Contract's Members into Disability Quintiles for the MA-PD Part D Summary 28
Table 18: Final Adjustment Categories and CAI Values for the MA-PD Part D Summary 28
Table 19: Categorization of Contract's Members into Quintiles of LIS/DE for the PDP Part D Summary 28
Table 20: Categorization of Contract's Members into Quintiles of Disability for the PDP Part D Summary 29
Table 21: Final Adjustment Categories and CAI Values for the PDP Part D Summary 29
CALCULATION PRECISION 29
ROUNDING RULES FOR MEASURE SCORES 30
ROUNDING RULES FOR SUMMARY AND OVERALL RATINGS 30
Table 22: Rounding Rules for Summary and Overall Ratings 30
METHODOLOGY FOR CALCULATING THE HIGH PERFORMING ICON 30
Figure 3: The High Performing Icon 31
METHODOLOGY FOR CALCULATING THE LOW PERFORMING ICON 31
Figure 4: The Low Performing Icon 31
Table 23: Example LPI Contracts 31
MERGERS, NOVATIONS, AND CONSOLIDATIONS 31
RELIABILITY REQUIREMENT FOR LOW-ENROLLMENT CONTRACTS 32
SPECIAL NEEDS PLAN (SNP) DATA 32
STAR RATINGS AND MARKETING 33
CONTACT INFORMATION 33
FRAMEWORK AND DEFINITIONS FOR THE DOMAIN AND MEASURE DETAILS SECTION 33
PART C DOMAIN AND MEASURE DETAILS 36
Domain: 1 - Staying Healthy: Screenings, Tests and Vaccines 36
Measure: C01 - Breast Cancer Screening 36
Measure: C02 - Colorectal Cancer Screening 38
Measure: C03 - Annual Flu Vaccine 39
Measure: C04 - Monitoring Physical Activity 41
Domain: 2 - Managing Chronic (Long Term) Conditions 43
Measure: C05 - Special Needs Plan (SNP) Care Management 43
Measure: C06 - Care for Older Adults – Medication Review 46
Measure: C07 - Care for Older Adults – Pain Assessment 47
Measure: C08 - Osteoporosis Management in Women who had a Fracture 48
Measure: C09 - Diabetes Care – Eye Exam 50
Measure: C10 - Diabetes Care – Blood Sugar Controlled 51
Measure: C11 - Controlling Blood Pressure 53
Measure: C12 - Reducing the Risk of Falling 55
Measure: C13 - Improving Bladder Control 57
Measure: C14 - Medication Reconciliation Post-Discharge 59
Measure: C15 - Plan All-Cause Readmissions 60
Measure: C16 - Statin Therapy for Patients with Cardiovascular Disease 61
Measure: C17 - Transitions of Care 63
Measure: C18 - Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions 65
Domain: 3 - Member Experience with Health Plan 67
Measure: C19 - Getting Needed Care 67
Measure: C20 - Getting Appointments and Care Quickly 68
Measure: C21 - Customer Service 69
Measure: C22 - Rating of Health Care Quality 70
Measure: C23 - Rating of Health Plan 72
Measure: C24 - Care Coordination 73
Domain: 4 - Member Complaints and Changes in the Health Plan's Performance 75

Measure: C25 - Complaints about the Health Plan 75
Measure: C26 - Members Choosing to Leave the Plan 76
Measure: C27 - Health Plan Quality Improvement 78
Domain: 5 - Health Plan Customer Service 80
Measure: C28 - Plan Makes Timely Decisions about Appeals 80
Measure: C29 - Reviewing Appeals Decisions 81
Measure: C30 - Call Center – Foreign Language Interpreter and TTY Availability 83
PART D DOMAIN AND MEASURE DETAILS 85
Domain: 1 - Drug Plan Customer Service 85
Measure: D01 - Call Center – Foreign Language Interpreter and TTY Availability 85
Domain: 2 - Member Complaints and Changes in the Drug Plan's Performance 87
Measure: D02 - Complaints about the Drug Plan 87
Measure: D03 - Members Choosing to Leave the Plan 88
Measure: D04 - Drug Plan Quality Improvement 90
Domain: 3 - Member Experience with the Drug Plan 92
Measure: D05 - Rating of Drug Plan 92
Measure: D06 - Getting Needed Prescription Drugs 93
Domain: 4 - Drug Safety and Accuracy of Drug Pricing 95
Measure: D07 - MPF Price Accuracy 95
Measure: D08 - Medication Adherence for Diabetes Medications 97
Measure: D09 - Medication Adherence for Hypertension (RAS antagonists) 100
Measure: D10 - Medication Adherence for Cholesterol (Statins) 103
Measure: D11 - MTM Program Completion Rate for CMR 105
Measure: D12 - Statin Use in Persons with Diabetes (SUPD) 108
ATTACHMENT A: CAHPS CASE-MIX ADJUSTMENT 111
CAHPS Case-Mix Adjustment 111
Table A-1: Coefficients of Part C Getting Needed Care (C19) CAHPS Measure Composite Items 112
Table A-2: Coefficients of Part C Getting Appointments and Care Quickly (C20) CAHPS Measure Composite Items 113
Table A-3: Coefficients of Part C Customer Service (C21) CAHPS Measure Composite Items 114
Table A-4: Coefficients of Part C Stand-alone CAHPS Measures 115
Table A-5: Coefficients of Part C Care Coordination (C24) CAHPS Measure Composite Items 116
Table A-6: Coefficients of Part D CAHPS Stand-alone Measures 117
Table A-7: Coefficients of Part D Getting Needed Prescription Drugs (D06) CAHPS Measure Composite Items 118
ATTACHMENT B: CALCULATING MEASURE DATA FOR THE SURVIVING CONTRACT OF A CONSOLIDATION 119
First Year Following a Consolidation 119
Table B-1: Enrollment Month Used in Calculating Measure Scores for the Surviving Contract of a Consolidation 119
Table B-2: Example of Calculating the Measure Score for the Surviving Contract of a Consolidation 119
Second Year Following a Consolidation 119
ATTACHMENT C: NATIONAL AVERAGES FOR PART C AND D MEASURES 120
Table C-1: National Averages for Part C Measures 120
Table C-2: National Averages for Part D Measures 121
ATTACHMENT D: PART C AND D DATA TIME FRAMES 122
Table D-1: Part C Measure Data Time Frames 122
Table D-2: Part D Measure Data Time Frames 123
ATTACHMENT E: SNP MEASURE SCORING METHODOLOGIES 124
1. Medicare Part C Reporting Requirements Measure (C05: SNP Care Management) 124
2. NCQA HEDIS Measures - (C06 – C07: Care for Older Adults) 124
Table E-1: Example Calculation Using Effectiveness of Care Rate 125
ATTACHMENT F: CALCULATING MEASURE C15: PLAN ALL-CAUSE READMISSIONS 126
Example: Calculating the final rate for Contract 1 126
ATTACHMENT G: WEIGHTS ASSIGNED TO INDIVIDUAL PERFORMANCE MEASURES 127

Table G-1: Part C Measure Weights 127
Table G-2: Part D Measure Weights 129

ATTACHMENT H: CALCULATION OF WEIGHTED STAR RATING AND VARIANCE ESTIMATES 130

ATTACHMENT I: CALCULATING THE IMPROVEMENT MEASURE AND THE MEASURES USED 131

Calculating the Improvement Measure 131

General Standard Error Formula 132

Improvement Change Score Standard Error Numerical Example 132

Standard Error Formulas (SEF) for Specific Measures 133

1. SEF for Measures: C01, C02, C04, C05, C08 – C14, C16, C26, C28 – C30, D01, D03, D08 – D12 133
2. SEF for Measures: C06, C07 133
3. SEF for Measures: C03, C19 – C24, and D05, D06 133
4. SEF for Measures C25, D02 134
5. SEF for Measure D07 135

Star Ratings Measures Used in the Improvement Measures 136

Table I-1: Part C Measures Used in the Improvement Measure 136

ATTACHMENT J: STAR RATINGS MEASURE HISTORY 138

Table J-1: Part C Measure History 138
Table J-2: Part D Measure History 143
Table J-3: Common Part C & Part D Measure History 147

ATTACHMENT K: INDIVIDUAL MEASURE STAR ASSIGNMENT PROCESS 148

Clustering Methodology Introduction 148

Figure K-1: Diagram showing gaps in data where cut points are assigned. 148

Example 1 – Clustering Methodology for a Higher is Better measure 148

Table K-1: Medication Adherence for Diabetes Medications cut points example: cut points are for illustrative purposes 149
Figure K-2: Diagram showing star assignment based cut points. 149

Example 2 – Clustering Methodology for a Lower is Better measure 149

Table K-2: Members Choosing to Leave the Plan cut points example: cut points are for illustrative purposes 149

Clustering Methodology Detail 150

1. Produce the individual measure distance matrix. 150
2. Create a tree of cluster assignments. 151
3. Select the final set of clusters from the tree of cluster assignments. 151
4. Final Thresholds 152

Determining Stars from Scores and Thresholds 152

Table K-3: 2024 Star Ratings Part C non-CAHPS Measure Mean Resampling Estimated Thresholds 153
Table K-4: 2024 Star Ratings Part D non-CAHPS Measure Mean Resampling Estimated Thresholds 154
Table K-5: 2024 Star Ratings Part C non-CAHPS Measure Tukey Outlier Cutoffs 155
Table K-6: 2024 Star Ratings Part D non-CAHPS Measure Tukey Outlier Cutoffs 156
Table K-7: 2023 Star Ratings Part C Mean Resampling and Tukey Outlier Deletion Non-CAHPS Measure Thresholds 157
Table K-8: 2023 Star Ratings Part D Mean Resampling and Tukey Outlier Deletion Non-CAHPS Measure Thresholds 158

Relative Distribution and Significance Testing (CAHPS) Methodology 158

Table K-9: CAHPS Star Assignment Rules 159
Table K-10: CAHPS Star Assignment Alternate Representation 160
Table K-11: CAHPS Measure 12% Reliability Cutoffs 160

ATTACHMENT L: MEDICATION ADHERENCE MEASURE CALCULATIONS 161

Proportion of Days Covered Calculation 161

Example 1: Non-Overlapping Fills of Two Different Drugs 161

Table L-1: No Adjustment 161

Example 2: Overlapping Fills of the Same Generic Ingredient across Single and Combination Products 161

Table L-2: Before Overlap Adjustment 162

Table L-3: After Overlap Adjustment 162
Example 3: Overlapping Fills of the Same and Different Target Drugs 162
Table L-4: Before Overlap Adjustment 162
Table L-5: After Overlap Adjustment 163
PDC Adjustment for Inpatient, and Skilled Nursing Facility Stays Examples 163
Calculating the PDC Adjustment for IP Stays and SNF Stays 163
Example 1: Gap in Coverage after IP Stay 164
Table L-6: Before Adjustment 164
Table L-7: After Adjustment 165
Example 2: Gap in Coverage before IP Stay 165
Table L-8: Before Adjustment 165
Table L-9: After Adjustment 165
Example 3: Gap in Coverage Before and After IP Stay 165
Table L-10: Before Adjustment 166
Table L-11: After Adjustment 166
Example 4: Gap in Coverage After IP Stay and Overlap with Subsequent Fill of the Same Drug Class 166
Table L-12: Before Adjustment 166
Table L-13: After Adjustment 167
ATTACHMENT M: METHODOLOGY FOR PRICE ACCURACY MEASURE 168
Contract Selection 168
MPF Composite Price Accuracy Score 168
Example of Accuracy Index Calculation 171
Table M-1: Example of Price Accuracy Index Calculation 172
PDE = PRESCRIPTION DRUG EVENT 172
MPF = MEDICARE PLAN FINDER 172
ATTACHMENT N: MTM CMR COMPLETION RATE MEASURE SCORING METHODOLOGIES 173
Medicare Part D Reporting Requirements Measure (D11: MTM CMR Completion Rate Measure) 173
ATTACHMENT O: METHODOLOGY FOR THE PUERTO RICO MODEL 175
Model 176
Example 177
ATTACHMENT P: IDENTIFICATION OF CONTRACTS AFFECTED BY DISASTERS 178
Operational Steps to Calculating Enrollment Impacted in Affected Contracts. 178
Table P-1: Section 1135 waivers issued in relation to the FEMA major disaster declarations 178
Table P-2: Individual Assistance counties in FEMA Major Disaster Declared States 179
Table P-3: Organization type service areas and necessary transformations 179
Table P-4: Major Disasters with associated enrollment months 180
Table P-5: How enrollment periods were combined for contracts experiencing multiple disasters 180
Example: 181
Table P-6: Example Contract HAAAA's Service Areas and Enrollment during Relevant Disasters 181
ATTACHMENT Q: MISSING DATA MESSAGES 183
Measure level messages 183
Table Q-1: Measure level missing data messages 183
Assignment rules for Part C measure messages 183
Assignment rules for Part D measure messages 187
Table Q-2: MTM CMR Reason(s) for Display Message conversion 189
Domain, Summary, and Overall level messages 189
Table Q-3: Domain, Summary, and Overall level missing data messages 189
Assignment rules for Part C & Part D domain rating level messages 189
Assignment rules for Part C & Part D summary rating level messages 189

Assignment rules for overall rating level messages **190**
Disenrollment Reasons messages **190**
Table Q-4: Disenrollment Reason missing data messages 190
ATTACHMENT R: GLOSSARY OF TERMS **191**
ATTACHMENT S: HEALTH PLAN MANAGEMENT SYSTEM MODULE REFERENCE **195**
HPMS Star Ratings Module **195**
1. Measure Data page 195
Table S-1: Measure Data page sample 195
Medicare Star Ratings Report Card Master Table 195
2. Measure Detail – CTM Summary page 196
Table S-2: Measure Detail – CTM Summary page fields 197
3. Measure Detail – Part C Appeals page 197
Table S-3: Measure Detail – Part C Appeals page fields 197
4. Measure Detail – SNP CM page 198
Table S-4: Measure Detail – SNP CM page fields 198
5. Measure Detail – HEDIS page 198
Table S-5: Measure Detail – HEDISpage fields 199
Table S-6: HEDIS 2022 Audit Designations and 2024 Star Ratings 199
6. Measure Detail – CTM page 199
Table S-7: Measure Detail – CTM page fields 200
7. Measure Detail – Disenrollment 200
Table S-8: Measure Detail – Disenrollment page fields 200
8. Measure Detail – DR (Disenrollment Reasons) 200
Table S-9: Measure Detail – Disenrollment Reasons page fields 201
9. Measure Detail – MTM page 201
Table S-10: Measure Detail – MTM page fields 201
10. Measure Detail – CAHPS page 202
Table S-11: Measure Detail – CAHPS page fields 202
11. Calculation Detail – MD 202
Table S-12: Calculation Detail – MD page fields 203
12. Calculation Detail – CAI 203
Table S-13: Measure Detail – CAI page fields 204
13. Measure Detail – HEDIS LE page 204
Table S-14: Measure Detail – HEDIS LE page fields 205
14. Measure Detail – C MD Results 205
Table S-15: Measure Detail – C MD Results 205
15. Measure Detail – D MD Results 205
Table S-16: Measure Detail – D MD Results 206
16. Measure Detail – C Improvement page 206
Table S-17: Part C Measure Improvement Results 206
17. Measure Detail – D Improvement page 206
Table S-18: Part D Measure Improvement Results 207
18. Measure Stars page 207
Table S-19: Measure Stars page sample 207
Medicare Star Ratings Report Card Master Table 207
19. Domain Stars page 207
Table S-20: Domain Star page sample 208
Medicare Star Ratings Report Card Master Table 208
20. Part C Summary Rating page 208
Table S-21: Part C Summary Rating page fields 208
21. Part D Summary Rating page 209
Table S-22: Part D Summary Rating View 209
22. Overall Rating page 209
Table S-23: Overall Rating View 210
23. Low Performing Contract List 210
Table S-24: Low Performing Contract List 211
24. High Performing Contract List 211

Table S-25: High Performing Contract List 211
25. Technical Notes link 211
26. Medication NDC List 212
27. Part C and Part D Example Measure Data 212

Introduction

CMS created the Part C & D Star Ratings to provide quality and performance information to Medicare beneficiaries to assist them in choosing their health and drug services during the annual fall open enrollment period. We refer to them as the '2024 Medicare Part C & D Star Ratings' because they are posted prior to the 2024 open enrollment period.

This document describes the methodology for creating the Part C & D Star Ratings displayed on the Medicare Plan Finder (MPF) at http://www.medicare.gov/ and posted on the CMS website at http://go.cms.gov/partcanddstarratings. A Glossary of Terms used in this document can be found in Attachment R.

The Star Ratings data are also displayed in the Health Plan Management System (HPMS). In HPMS, the data can be found by selecting: "Quality and Performance," then "Performance Metrics," then "Reports," then "Star Ratings and Display Measures," then "Star Ratings" for the report type, and "2024" for the report period. See Attachment S: Health Plan Management System Module Reference for descriptions of the HPMS pages.

The Star Ratings Program is consistent with the "Meaningful Measures" framework which focuses on measures related to person-centered care, equity, safety, affordability and efficiency, chronic conditions, wellness and prevention, seamless care coordination, and behavioral health. With Meaningful Measures 2.0, CMS plans to better address health care priorities and gaps, emphasize digital quality measurement, and promote patient perspectives of care. The Star Ratings include measures applying to the following five broad categories:

- Outcomes: Outcome measures reflect improvements in a beneficiary's health and are central to assessing quality of care.
- Intermediate outcomes: Intermediate outcome measures reflect actions taken which can assist in improving a beneficiary's health status. Diabetes Care – Blood Sugar Controlled is an example of an intermediate outcome measure where the related outcome of interest would be better health status for beneficiaries with diabetes.
- Patient experience: Patient experience measures reflect beneficiaries' perspectives of the care they received.
- Access: Access measures reflect processes and issues that could create barriers to receiving needed care. Plan Makes Timely Decisions about Appeals is an example of an access measure.
- Process: Process measures capture the health care services provided to beneficiaries which can assist in maintaining, monitoring, or improving their health status.

Differences between the 2023 Star Ratings and 2024 Star Ratings

There have been several changes between the 2023 Star Ratings and the 2024 Star Ratings. This section provides a synopsis of the notable differences; the reader should examine the entire document for full details about the 2024 Star Ratings. A table with the complete history of measures used in the Star Ratings can be found in Attachment J.

- Changes
    a. Tukey outer fence outlier deletion was added to the hierarchical clustering methodology that is used to set cut points for non-CAHPS measures.
    b. The disaster policy was modified to include data integrity issues in the definition of missing data, such that disaster-affected contracts with a data integrity issue on a given measure received the final measure rating from the current year.

c. The weight for the Part C Controlling Blood Pressure measure was increased to 3.
d. Re-specified Part C Plan All-Cause Readmissions measure moved into the 2024 Star Ratings as a new measure with a weight of 1 for the first year.
e. The Part C Transitions of Care measure was added to the 2024 Star Ratings with a weight of 1.
f. The Part C Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions measure was added to the 2024 Star Ratings with a weight of 1.

- Transitioned measures (Moved to the display page on the CMS website: http://go.cms.gov/partcanddstarratings)
  a. None
- Retired measures
  a. Part C measure – Diabetes Care – Kidney Disease Monitoring

Health/Drug Organization Types Included in the Star Ratings

All health and drug plan quality and performance measure data described in this document are reported at the contract/sponsor level. Table 1 lists the contract year 2024 organization types and whether they are included in the Part C and/or Part D Star Ratings.

Table 1: Contract Year 2024 Organization Types Reported in the 2024 Star Ratings

Organization Type	Technical Notes Abbreviation	Medicare Advantage (MA)	Can Offer SNPs	Part C Ratings	Part D Ratings
1876 Cost	1876 Cost	No	No	Yes	Yes (if drugs offered)
Demonstration (Medicare-Medicaid Plan) †	MMP	No	No	No	No
Employer/Union Only Direct Contract Local Coordinated Care Plan (CCP)	CCP	Yes	No	Yes	Yes
Employer/Union Only Direct Contract Prescription Drug Plan (PDP)	PDP	No	No	No	Yes
Employer/Union Only Direct Contract Private Fee-for-Service (PFFS)	PFFS	Yes	No	Yes	Yes (if drugs offered)
HCPP 1833 Cost	HCPP	No	No	No	No
Local Coordinated Care Plan (CCP)	CCP	Yes	Yes	Yes	Yes
Medical Savings Account (MSA)	MSA	Yes	No	Yes	No
National PACE	PACE	No	No	No	No
Medicare Prescription Drug Plan (PDP)	PDP	No	No	No	Yes
Private Fee-for-Service (PFFS)	PFFS	Yes	No	Yes	Yes (if drugs offered)
Regional Coordinated Care Plan (CCP)	CCP	Yes	Yes	Yes	Yes
Religious Fraternal Benefit Private Fee-for-Service (RFB PFFS)	PFFS	Yes	No	Yes	Yes (if drugs offered)

† Note: The measure scores from these organizations are displayed in HPMS only during the first plan preview. Data from these organizations are not used in calculating the Part C & D Star Ratings.

The Star Ratings Framework

The Star Ratings are based on health and drug plan quality and performance measures. Each measure is reported in two ways:

Score: A score is either a numeric value or an assigned 'missing data' message.

Star: The measure numeric value is converted to a Star Rating.

The measure Star Ratings are combined into three groups and each group is assigned 1 to 5 stars. The three groups are:

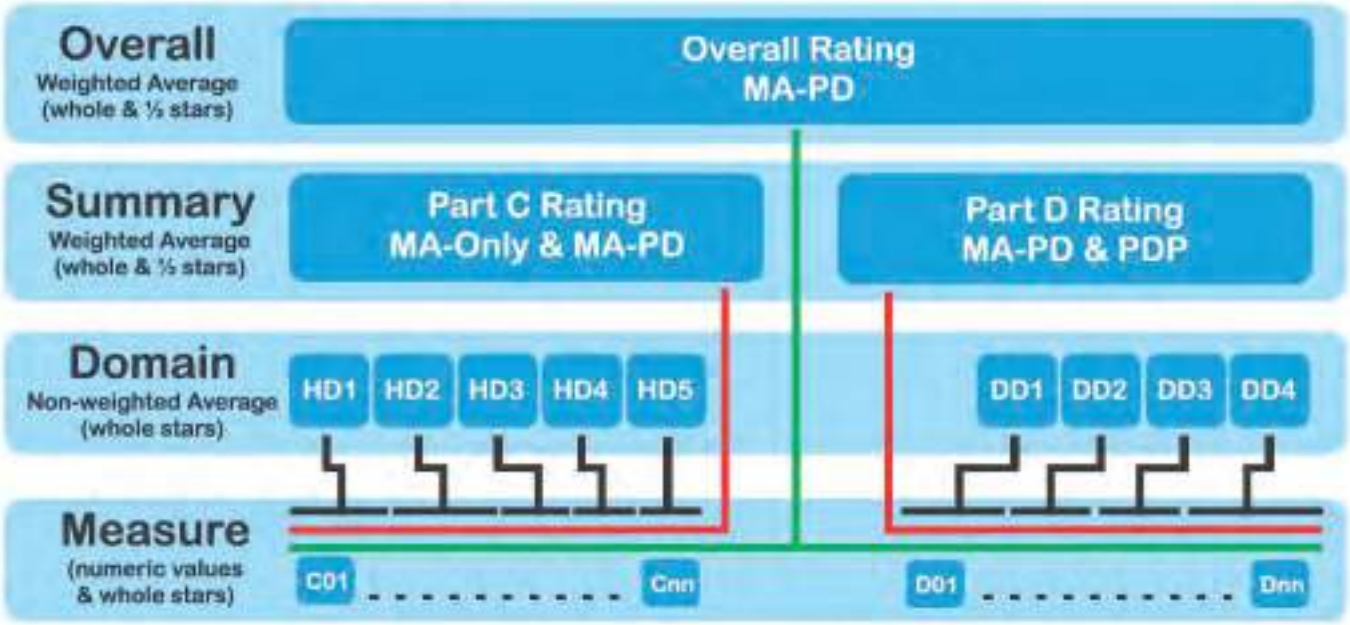
Domain: Domains group together measures of similar services. Star Ratings for domains are calculated using the non-weighted average Star Ratings of the included measures.

Summary: Part C measures are grouped to calculate a Part C Rating; Part D measures are grouped to calculate a Part D Rating. Summary ratings are calculated from the weighted average Star Ratings of the included measures.

Overall: For MA-PDs, all unique Part C and Part D measures are grouped to create an overall rating. The overall rating is calculated from the weighted average Star Ratings of the included measures.

Figure 1 shows the four levels of Star Ratings that are calculated and reported publicly.

Figure 1: The Four Levels of Star Ratings



The whole star scale used at the measure and domain levels is shown in Table 2.

Table 2: 5-Star Scale

Numeric	Graphic	Description
5	★★★★★	Excellent
4	★★★★	Above Average
3	★★★	Average
2	★★	Below Average
1	★	Poor

To allow for more variation across contracts, CMS assigns half stars to the summary and overall ratings.
As different organization types offer different benefits, CMS classifies contracts into three contract types. The highest level Star Rating differs among the contract types because the set of required measures differs by contract type. Table 3 clarifies how CMS classifies contracts for purposes of the Star Ratings and indicates the highest rating available for each organization type.

Table 3: Relation of 2024 Organization Types to Contract Types and Highest Rating in the 2024 Star Ratings

Organization Type	1876 Cost (no drugs) †	1876 Cost (offers drugs) †	CCP	MSA	PDP	PFFS (no drugs)	PFFS (offers drugs)
Rated As	MA-Only	MA-PD	MA-PD	MA-Only	PDP	MA-Only	MA-PD
Highest Rating	Part C rating	Overall Rating	Overall Rating	Part C Rating	Part D Rating	Part C Rating	Overall Rating

† Note: While 1876 contracts are not MA contracts, for the purposes of determining the highest rating they are considered to be rated as either "MA-only" or "MA-PD" depending on whether they offer drugs.

Sources of the Star Ratings Measure Data

The 2024 Star Ratings include a maximum of 9 domains comprised of a maximum of 42 measures.

- MA-Only contracts are measured on 5 domains with a maximum of 30 measures.
- PDPs are measured on 4 domains with a maximum of 12 measures.
- MA-PD contracts are measured on all 9 domains with a maximum of 42 measures, 40 of which are unique measures. Two of the measures are shown in both Part C and Part D so that the results for a MA-PD contract can be compared to an MA-Only contract or a PDP contract. Only one instance of those two measures is used in calculating the overall rating. The two duplicated measures are Complaints about the Health/Drug Plan (CTM) and Members Choosing to Leave the Plan (MCLP).

For a health and/or drug plan to be included in the Part C & D Star Ratings, they must have an active contract with CMS to provide health and/or drug services to Medicare beneficiaries. All of the data used to rate the plans are collected through normal contractual requirements or directly from CMS systems. Information about Medicare Advantage contracting can be found at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html and Prescription Drug Coverage contracting at: https://www.cms.gov/Medicare/Prescription-Drug-coverage/PrescriptionDrugCovContra/index.html. The data used in the Star Ratings come from four categories of data sources which are shown in Figure 2.

Figure 2: The Four Categories of Data Sources

Improvement Measures

Unlike the other Star Rating measures which are derived from data sources external to the Star Ratings, the Part C and Part D improvement measures are derived through comparisons of a contract's current and prior year measure scores. For a measure to be included in the improvement calculation the measure must not have had a significant specification change during those years. The Part C improvement measure includes only Part C measure scores and the Part D improvement measure includes only Part D measure scores. The measures and formulas for the improvement measure calculations are found in Attachment I. If a scaled reduction is applied to the Part C appeals measure in the previous year, the associated appeals measures will not be included in the Health Plan Quality Improvement measure.

The numeric results of these calculations are not publicly posted; only the measure ratings are reported publicly. Further, to receive a Star Rating in the improvement measures, a contract must have measure scores for both years in at least half of the required measures used to calculate the Part C improvement or Part D improvement measures. Improvement scores are not calculated for reconfigured regional contracts until data is available for the reconfigured structure from both years. Improvement scores are not calculated for consolidated contracts in their first year. Table 4 presents the minimum number of measure scores required to receive a rating for the improvement measures.

Table 4: Minimum Number of Measure Scores Required for an Improvement Measure Rating by Contract Type

Part	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
C	11 of 21	12 of 23	13 of 26	7 of 14	11 of 22	N/A	12 of 23
D	5 of 10*	6of 11	6 of 11	5 of 9	N/A	6 of 11	6 of 11*

* Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.

For a detailed description of all Part C and Part D measures, see the section entitled "Framework and Definitions for the Domain and Measure Details."

Contract Enrollment Data

The enrollment data used in the Part C and Part D "Complaints about the Health/Drug Plan" measures are pulled from HPMS. These enrollment files represent the number of enrolled beneficiaries the contract was paid for in a specific month. For these measures, twelve months of enrollment files are pulled (January 2022 through December 2022) and the average enrollment across those months is used in the calculations.

Enrollment data are also used when combining the plan-level data into contract-level data in the two Part C "Care for Older Adults" Healthcare Effectiveness Data and Information Set (HEDIS) measures. ("The Care for Older Adults – Functional Status Assessment" measure is currently on the display page). When there is a reported rate, the eligible population in the plan benefit package (PBP) submitted with the HEDIS data is used. If the audit designation for the PBP level HEDIS data is set to "Not Reported" (NR) or "Biased Rate" (BR) by the auditor (see following section), there is no value in the eligible population field. In these instances, twelve months of PBP-level enrollment files are pulled (January 2022 through December 2022), and the average enrollment in the plan across those months is used in calculating the combined rate.

Handling of Biased, Erroneous, and/or Not Reportable (NR) Data

The data used for CMS's Star Ratings must be accurate and reliable. CMS has identified issues with some contracts' data and has taken steps to protect the integrity of the data. For any measure scores CMS identifies to be based on inaccurate or biased data, CMS's policy is to reduce a contract's measure rating to 1 star and set the measure score to "CMS identified issues with this plan's data."

Inaccurate or biased data result from the mishandling of data, inappropriate processing, or implementation of incorrect practices. Examples include, but are not limited to: a contract's failure to adhere to HEDIS, Health Outcomes Survey (HOS), or CAHPS reporting requirements; a contract's failure to adhere to Medicare Plan Finder data requirements; a contract's errors in processing organization determinations and appeals; compliance actions taken against the contract due to errors in operational areas that impact the data reported or processed for specific measures; or a contract's failure to pass validation of the data reported for specific measures. For HEDIS data, CMS uses the audit designation information assigned by the HEDIS auditor. An audit designation of 'NR' (Not reported) is assigned when the contract chooses not to report the measure. An audit designation of 'BR' (Biased rate) is assigned when the individual measure score is materially biased (e.g., the auditor informs the contract the data cannot be reported to the National Committee for Quality Assurance (NCQA) or to CMS). When either a 'BR' or 'NR' designation is assigned to a HEDIS measure audit designation, the contract receives 1 star for the measure and the measure score is set to "CMS identified issues with this plan's data." In addition, CMS reduces contracts' HEDIS measure ratings to 1 star if the patient-level data files are not successfully submitted and validated by the submission deadline. Also, if the HEDIS summary-level data value varies substantially from the value in the patient-level data, the measure is reduced to a rating of 1 star. If an approved CAHPS or HOS vendor does not submit a contract's CAHPS or HOS data by

the data submission deadline, the contract automatically receives a rating of 1 star for the CAHPS or HOS measures and the measure scores are set to "CMS identified issues with this plan's data."

Data Handling of Measures for Contracts Affected by a Major Disaster

CMS has a policy for making adjustments in the Star Ratings to take into account major disasters. That policy was described in the 2024 Rate Announcement (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.) This is also codified in regulation at §422.166(i) and §423.186(i).

This section describes how the policy is implemented for measures from each of the different data sources in the 2024 Star Ratings. The methodology used by CMS to identify the major disaster geographic areas, determine which contracts were affected, and how much of their geographic service area and percent of enrollment resided in an affected area can be found in Attachment P.

The disaster policy specified two distinct thresholds of "25% or more" and "60% or more" of the contract's membership at the time of the disaster resided in a FEMA-designated Individual Assistance area. CMS calculated the percentage of enrollment affected for every contract being rated and applied the following rules to the data from those contracts that meet or exceed either of the two thresholds.

- CAHPS adjustments:
  - All contracts were required to administer the 2023 CAHPS survey unless the contract requested and CMS approved an exemption.
  - All affected contracts with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster receive the higher of the 2023 or the 2024 Star Rating (and corresponding measure score) for each CAHPS measure (including the annual flu vaccine measure).
  - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated individual Assistance areas that were affected by disasters than began in 2022 were also affected by disasters in 2021. These doubly-affected contracts receive the higher of the 2024 Star Rating or what the 2023 Star Ratings would have been in the absence of any adjustments that took into account the effects of the 2021 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected). For example, if doubly-affected contract reverted back to the 2022 Star Rating on a given measure in the 2023 Star Ratings, the 2022 Star Rating is *not* used in determining the 2024 Star Rating. Rather the 2024 Star Rating is compared to what the 2023 Star Rating would have been absent any disaster adjustments.
- HEDIS-HOS adjustments:
  - The HEDIS-HOS data used in the 2024 Star Ratings are adjusted for 2021 disasters (see Attachment P of the 2023 Star Ratings Technical Notes for the identification of contracts affected by 2021 disasters).
  - All affected contracts (i.e., contracts affected by 2021 disasters) with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster received the higher of the 2023 or the 2024 Star Rating (and corresponding measure score) for each HEDIS-HOS measure.
  - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas affected by disasters that began in 2021 were also affected by disasters in 2020. These doubly-affected contracts receive the higher of the 2024 Star Rating or what the 2023 Star Rating would have been in the absence of any adjustments that took into account the effects of the

2020 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected).

- HEDIS adjustments:
  - All contracts were required to report HEDIS 2023 unless the contract requested and CMS approved an exemption. Contracts were able to work with NCQA to adjust samples if necessary.
  - Contracts with 25% or more affected members received the higher of the 2023 or 2024 Star Rating (and corresponding measure scores) for each HEDIS measure.
  - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas affected by disasters that began in 2022 were also affected by disasters in 2021. These doubly-affected contracts receive the higher of the 2024 Star Rating or what the 2023 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2021 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected).
- Part C and D Call Center:
  - For all contracts, no adjustments were made.
- New measures:
  - Contracts with 25% or more affected members have a hold harmless provision applied which compares the result of a contract's overall rating "with" and "without" including the new Transitions of Care and Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions measures and respecified Plan All-Cause Readmissions measure. If the "with" result is lower than the "without" result, then we use the "without" result as the final highest level rating.
  - A similar hold harmless provision is applied for the Part C summary ratings. If a contract has 25% or more affected members, the Part C summary rating is calculated "with" and "without" the new Transitions of Care and Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions measures and respecified Plan All-Cause Readmissions measure, and if the "with" result is lower than the "without" result, then we use the "without" result for the final summary rating.
- All other measures:
  - Contracts with 25% or more affected members receive the higher of the 2023 or 2024 measure stars (and corresponding measure scores).
  - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas affected by disasters that began in 2022 were also affected by disasters in 2021. These doubly-affected contracts receive the higher of the 2024 Star Rating or what the 2023 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2021 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected).
- All adjustments:
  - For all adjustments, if the Star Rating is the same in both years, the Star Rating and the measure score from the most recent year are used.
- Improvement measures:
  - For affected contracts that reverted back to the data underlying the previous year's Star Rating for a particular measure for either 2023 or 2024 Star Ratings, that measure is excluded from both the

count of measures (used to determine whether the contract has at least half of the measures needed to calculate the relevant improvement measure) and the improvement measures calculation. Affected contracts do not have the option of reverting to the prior year's improvement rating.

- Affected contracts with missing data:
  - If an affected contract has missing data in either the current or previous year (e.g., because of a data integrity issue, it is too new, or it is too small), the final measure rating comes from the current year. Missing data includes data where there is a data integrity issue.
- Reward factor:
  - Affected contracts with 60% or more of their enrollees impacted by a 2022 disaster are excluded from the determination of the performance summary and variance thresholds for the Reward Factor.
- Cut points:
  - Clustering Methodology: For all measures that use the clustering methodology for cut point generation, the measure scores for contracts with 60% or more of their enrollment affected by a disaster are excluded from creating those cut points.

Methodology for Assigning Stars to the Part C and Part D Measures

CMS assigns stars for each numeric measure score by applying one of two methods: clustering, or relative distribution and significance testing. Each method is described below. Attachment K explains the clustering and relative distribution and significance testing (used for CAHPS measures) methods in greater detail.

The *Cut Point Trend* document is posted at http://go.cms.gov/partcanddstarratings and is updated after each rating cycle is released.

A. Clustering

This method is applied to the majority of the Star Ratings measures, ranging from operational and process-based measures, to HEDIS and other clinical care measures. Using this method, the Star Rating for each measure is determined by applying a clustering algorithm to the measure's numeric value scores from all contracts. Conceptually, the clustering algorithm identifies the "gaps" among the scores and creates four cut points resulting in the creation of five levels (one for each Star Rating). The scores in the same Star Rating level are as similar as possible; the scores in different Star Rating levels are as different as possible. Star Rating levels 1 through 5 are assigned with 1 being the worst and 5 being the best.

Technically, the variance in measure scores is separated into within-cluster and between-cluster sum of squares components. The clusters reflect the groupings of numeric value scores that minimize the variance of scores within the clusters. The Star Ratings levels are assigned to the clusters that minimize the within-cluster sum of squares. The cut points for star assignments are derived from the range of measure scores per cluster, and the star levels associated with each cluster are determined by ordering the means of the clusters.

Tukey outlier deletion is used to determine the cut points for all non-CAHPS measures. Tukey outlier deletion involves removing Tukey outer fence outlier contract scores, those defined as measure-specific scores outside the bounds of 3.0 times the measure-specific interquartile range subtracted from the 1st quartile or added to the 3rd quartile. Outliers are removed prior to applying mean resampling within the hierarchical clustering algorithm.

Mean resampling is used to determine the cut points for all non-CAHPS measures. With mean resampling, measure-specific scores for the current year's Star Ratings are randomly separated into 10 equal-sized groups.

The hierarchal clustering algorithm is then applied 10 times, each time leaving one of the 10 groups out of the clustered data. The method results in 10 sets of measure-specific cut points. The mean for each 1 through 5 star level cut point is taken across the 10 sets for each measure to produce the final cut points.

Guardrails are used to cap the amount of increase or decrease in measure cut point values from one year to the next. Specifically, each 1 to 5 star level cut point is compared to the prior year's value and capped at an increase or decrease of at most 5 percentage points for measures having a 0 to 100 scale (absolute percentage cap) or at most 5 percent of the prior year's restricted score range for measures not having a 0 to 100 scale (restricted range cap). The final capped cut points after comparing each 1 through 5 star level cut point to the prior year's values are used for assigning measure stars.

B. Relative Distribution and Significance Testing (CAHPS)

This method is applied to determine valid star cut points for CAHPS measures. In order to account for the reliability of scores produced from the CAHPS survey, the method combines evaluating the relative percentile distribution with significance testing. For example, to obtain 5 stars, a contract's CAHPS measure score needs to be ranked at least at the 80th percentile and be statistically significantly higher than the national average CAHPS measure score, as well as either have not low reliability or have a measure score more than one standard error above the 80th percentile. To obtain 1 star, a contract's CAHPS measure score needs to be ranked below the 15th percentile and be statistically significantly lower than the national average CAHPS measure score, as well as either have not low reliability or have a measure score more than one standard error below the 15th percentile.

Methodology for Calculating Stars at the Domain Level

A domain rating is the average, unweighted mean, of the domain's measure stars. To receive a domain rating, a contract must meet or exceed the minimum number of rated measures required for the domain. The minimum number of rated measures required for a domain is determined based on whether the total number of measures in the domain for a contract type is odd or even:

- If the total number of measures that comprise the domain for a contract type is odd, divide the number of measures in the domain by two and round the quotient to the next whole number.
  - Example: If the total number of measures required in a domain for a contract type is 3, the value 3 is divided by 2. The quotient, in this case 1.5, is then rounded to the next whole number. To receive a domain rating, the contract must have a Star Rating for at least 2 of the 3 required measures.
- If the total number of measures that comprise the domain for a contract type is even, divide the number of measures in the domain by two and add one to the quotient.
  - Example: If the total number of measures required in a domain for a contract type is 6, the value 6 is divided by 2. In this example, 1 is then added to the quotient of 3. To receive a domain rating, the contract must have a Star Rating for at least 4 of the 6 required measures.

Table 5 details the minimum number of rated measures required for a domain rating by contract type.

Table 5: Minimum Number of Rated Measures Required for a Domain Rating by Contract Type

Part	Domain Name (Identifier)	1876 Cost †	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
C	Staying Healthy: Screenings, Tests and Vaccines (HD1)	3 of 4	3 of 4	3 of 4	2 of 2	3 of 4	N/A	3 of 4
C	Managing Chronic (Long Term) Conditions (HD2)	5 of 8	6 of 11	8 of 14	6 of 10	6 of 11	N/A	6 of 11
C	Member Experience with Health Plan (HD3)	4 of 6	4 of 6	4 of 6	N/A	4 of 6	N/A	4 of 6
C	Member Complaints and Changes in the Health Plan's Performance (HD4)	2 of 3	2 of 3	2 of 3	2 of 3	2 of 3	N/A	2 of 3
C	Health Plan Customer Service (HD5)	2 of 2	2 of 3	2 of 3	2 of 3	2 of 2	N/A	2 of 3
D	Drug Plan Customer Service (DD1)	N/A*	1 of 1	1 of 1	1 of 1	N/A	1 of 1	1 of 1*
D	Member Complaints and Changes in the Drug Plan's Performance (DD2)	2 of 3*	2 of 3	2 of 3	2 of 3	N/A	2 of 3	2 of 3*
D	Member Experience with the Drug Plan (DD3)	2 of 2*	2 of 2	2 of 2	N/A	N/A	2 of 2	2 of 2*
D	Drug Safety and Accuracy of Drug Pricing (DD4)	4 of 6*	4 of 6	4 of 6	4 of 6	N/A	4 of 6	4 of 6*

* Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.
† Note: 1876 Cost contracts that offer drug benefits and which do not submit data for the MPF measure must have a rating in 3 out of 5 Drug Safety and Accuracy of Drug Pricing (DD4) measures to receive a rating in that domain.

Summary and Overall Ratings: Weighting of Measures

The summary and overall ratings are calculated as weighted averages of the measure stars. For the 2024 Star Ratings, CMS assigns the highest weight to the improvement measures, followed by patient experience/complaints and access measures, then by outcome and intermediate outcome measures, and finally process measures. New measures included in the Star Ratings are given a weight of 1 for their first year of inclusion in the ratings; in subsequent years the weight associated with the measure weighting category is used. The weights assigned to each measure and their weighting category are shown in Attachment G.
In calculating the summary and overall ratings, a measure given a weight of 3 counts three times as much as a measure given a weight of 1. For any given contract, any measure without a rating is not included in the calculation. The first step in the calculation is to multiply each measure's weight by the measure's rating and sum these results. The second step is to divide this sum by the sum of the weights of the contract's rated measures. For the summary and overall ratings, half stars are assigned to allow for more variation across contracts.

Methodology for Calculating Part C and Part D Summary Ratings

The Part C and Part D summary ratings are calculated by taking a weighted average of the measure stars for Parts C and D, respectively. To receive a Part C and/or Part D summary rating, a contract must meet the minimum number of rated measures. The Parts C and D improvement measures are not included in the count of the minimum number of rated measures. The minimum number of rated measures required is determined as follows:

- If the total number of measures required for the organization type is odd, divide the number by two and round it to a whole number.
  - Example: if there are 13 required Part D measures for the organization, 13 / 2 = 6.5, when rounded the result is 7. The contract needs at least 7 measures with ratings out of the 13 total measures to receive a Part D summary rating.
- If the total number of measures required for the organization type is even, divide the number of measures by two.
  - Example: if there are 30 required Part C measures for the organization, 30 / 2 = 15. The contract needs at least 15 measures with ratings out of the 30 total measures to receive a Part C summary rating.

Table 6 shows the minimum number of rated measures required by each contract type to receive a summary rating.

Table 6: Minimum Number of Rated Measures Required for Part C and Part D Ratings by Contract Type

Rating	1876 Cost †	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Part C summary	11 of 22	13 of 26	15 of 29	9 of 17	13 of 25	N/A	13 of 26
Part D summary	5 of 10*	6 of 11	6 of 11	5 of 9	N/A	6 of 11	6 of 11*

* Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.
† Note: 1876 Cost contracts which do not submit data for the MPF measure must have ratings in 5 out of 9measures to receive a Part D rating.

Methodology for Calculating the Overall MA-PD Rating

For MA-PDs to receive an overall rating, the contract must have stars assigned to both the Part C and Part D summary ratings. If an MA-PD contract has only one of the two required summary ratings, the overall rating will show as "Not enough data available."

The overall rating for a MA-PD contract is calculated using a weighted average of the Part C and Part D measure stars. The weights assigned to each measure are shown in Attachment G.

There are a total of 42 measures (30 in Part C, 12 in Part D) in the 2024 Star Ratings. The following two measures are contained in both the Part C and D measure lists:

- Complaints about the Health/Drug Plan (CTM)
- Members Choosing to Leave the Plan (MCLP)

These measures share the same data source, so CMS includes only one instance of each of these two measures in the calculation of the overall rating. In addition, the Part C and D improvement measures are not included in the count for the minimum number of measures. Therefore, a total of 38 distinct measures are used in the calculation of the overall rating.

The minimum number of rated measures required for an overall MA-PD rating is determined using the same methodology as for the Part C and D summary ratings. Table 7 provides the minimum number of rated measures required for an overall Star Rating by contract type.

Table 7: Minimum Number of Rated Measures Required for an Overall Rating by Contract Type

Rating	1876 Cost †	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Overall Rating	15 of 30*	18 of 35	19 of 38	12 of 24	N/A	N/A	18 of 35*

* Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.
† Note: 1876 Cost contracts which do not submit data for the MPF measure must have ratings in 15 out of 29 measures to receive an overall rating.

Completing the Summary and Overall Rating Calculations

There are two adjustments made to the results of the summary and overall calculations described above. First, to reward consistently high performance, CMS utilizes both the mean and the variance of the measure stars to differentiate contracts for the summary and overall ratings. If a contract has both high and stable relative performance, a reward factor is added to the contract's ratings. Details about the reward factor can be found in the section entitled "Applying the Reward Factor." Second, the summary and overall ratings include a Categorical Adjustment Index (CAI) factor, which is added to or subtracted from a contract's summary and overall ratings. Details about the CAI can be found in the section entitled "Categorical Adjustment Index (CAI)."

The summary and overall rating calculations are run twice, once including the improvement measures and once without including the improvement measures. Based on a comparison of the results of these two calculations a decision is made as to whether the improvement measures are to be included in calculating a contract's final summary and overall ratings. Details about the application of the improvement measures can be found in the section entitled "Applying the Improvement Measure(s)."

Lastly, standard rounding rules are applied to convert the results of the final summary and overall ratings calculations into the publicly reported Star Ratings. Details about the rounding rules are presented in the section "Rounding Rules for Summary and Overall Ratings."

Applying the Improvement Measure(s)

The Part C Improvement Measure - Health Plan Quality Improvement (C27) and the Part D Improvement Measure - Drug Plan Quality Improvement (D04) were introduced earlier in this document in the section entitled "Improvement Measures." The measures and formulas for the improvement measures can be found in Attachment I. This section discusses whether and how to apply the improvement measures in calculating a contract's final summary and overall ratings.

Since high performing contracts have less room for improvement and consequently may have lower ratings on these measure(s), CMS has developed the following rules to not penalize contracts receiving 4 or more stars for their highest rating.

MA-PD Contracts

1. There are separate Part C and Part D improvement measures (C27 & D04) for MA-PD contracts.
   a. C27 is used in calculating the Part C summary rating of an MA-PD contract.
   b. D04 is used in calculating the Part D summary rating for an MA-PD contract.
   c. Both improvement measures will be used when calculating the overall rating in step 3.
2. Calculate the overall rating for MA-PD contracts without including either improvement measure.
3. Calculate the overall rating for MA-PD contracts with both improvement measures included.

4. If an MA-PD contract in step 2 has 4 or more stars, compare the two overall ratings. If the rating in step 3 is less than the value in step 2, use the overall rating from step 2; otherwise use the result from step 3.
5. For all other MA-PD contracts, use the overall rating from step 3.

MA-Only Contracts

1. Only the Part C improvement measure (C27) is used for MA-Only contracts.
2. Calculate the Part C summary rating for MA-Only contracts without including the improvement measure.
3. Calculate the Part C summary rating for MA-Only contracts with the Part C improvement measure.
4. If an MA-Only contract in step 2 has 4 or more stars, compare the two Part C summary ratings. If the rating in step 3 is less than the value in step 2, use the Part C summary rating from step 2; otherwise use the result from step 3.
5. For all other MA-Only contracts, use the Part C summary rating from step 3.

PDP Contracts

1. Only the Part D improvement measure (D04) is used for PDP contracts.
2. Calculate the Part D summary rating for PDP contracts without including the improvement measure.
3. Calculate the Part D summary rating for PDP contracts with the Part D improvement measure.
4. If a PDP contract in step 2 has 4 or more stars, compare the two Part D summary ratings. If the rating in step 3 is less than the value in step 2, use the Part D summary rating from step 2; otherwise use the result from step 3.
5. For all other PDP contracts, use the Part D summary rating from step 3.

Applying the Reward Factor

The following represents the steps taken to calculate and include the reward factor (r-Factor) in the Star Ratings summary and overall ratings. These calculations are performed both with and without the improvement measures included.

- Calculate the mean and the variance of all of the individual quality and performance measure stars at the contract level.
  - The mean is equal to the summary or overall rating before the reward factor is applied, which is calculated as described in the section entitled “Weighting of Measures.”
  - Using weights in the variance calculation accounts for the relative importance of measures in the reward factor calculation. To incorporate the weights shown in Attachment G into the variance calculation of the available individual performance measures for a given contract, the steps are as follows:
    - Subtract the summary or overall star from each performance measure’s star; square the results; and multiply each squared result by the corresponding individual performance measure weight.
    - Sum these results; call this ‘SUMWX.’
    - Set n equal to the number of individual performance measures available for the given contract.
    - Set W equal to the sum of the weights assigned to the n individual performance measures available for the given contract.
    - The weighted variance for the given contract is calculated as: $n * SUMWX / (W * (n-1))$. For the complete formula, please see Attachment H: Calculation of Weighted Star Rating and Variance Estimates.

- Categorize the variance into three categories:
  - low (0 to less than 30th percentile),
  - medium (greater than or equal to 30th to less than 70th percentile) and
  - high (greater than or equal to 70th percentile)
- Develop the reward factor as follows:
  - r-Factor = 0.4 (for contract w/ low variance & high mean (mean greater than or equal to 85th percentile))
  - r-Factor = 0.3 (for contract w/ medium variance & high mean (mean greater than or equal to 85th percentile))
  - r-Factor = 0.2 (for contract w/ low variance & relatively high mean (mean greater than or equal to 65th & less than 85th percentile))
  - r-Factor = 0.1 (for contract w/ medium variance & relatively high mean (mean greater than or equal to 65th & less than 85th percentile))
  - r-Factor = 0.0 (for all other contracts)

Tables 8 and 9 show the final threshold values used in reward factor calculations for the 2024 Star Ratings.

Table 8: Performance Summary Thresholds

Improvement	New Measures	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
With	With	65th	3.783333	3.702703	3.500000	3.700515
With	With	85th	4.121212	4.000000	3.857143	3.989691
With	Without	65th	3.810345	3.702703	3.500000	3.724138
With	Without	85th	4.169231	4.000000	3.857143	4.030928
Without	With	65th	3.848485	3.71875	3.631579	3.741573
Without	With	85th	4.169231	4.09375	3.937500	4.061111
Without	Without	65th	3.873016	3.71875	3.631579	3.759036
Without	Without	85th	4.225806	4.09375	3.937500	4.102564

Table 9: Variance Thresholds

Improvement	New Measures	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
With	With	30th	0.924375	0.860382	0.965801	0.972245
With	With	70th	1.482292	1.536357	1.548310	1.460744
With	Without	30th	0.894302	0.860382	0.965801	0.952953
With	Without	70th	1.486442	1.536357	1.548310	1.454437
Without	With	30th	0.876231	0.806738	0.751953	0.917753
Without	With	70th	1.485714	1.557540	1.419580	1.489974
Without	Without	30th	0.845782	0.806738	0.751953	0.893483
Without	Without	70th	1.496943	1.557540	1.419580	1.479720

Categorical Adjustment Index (CAI)

CMS has implemented an analytical adjustment called the Categorical Adjustment Index (CAI). The CAI is a factor that is added to or subtracted from a contract's Overall and/or Summary Star Ratings to adjust for the

average within-contract disparity in performance for Low Income Subsidy/Dual Eligible (LIS/DE) beneficiaries and disabled beneficiaries. The CAI value (factor) depends on the contract's percentage of beneficiaries with LIS/DE and the contract's percentage of beneficiaries with disabled status. These adjustments are performed both with and without the improvement measures included. The value of the CAI varies by the contract's percentage of beneficiaries with LIS/DE and disability status.

The CAI values use data collected for the 2023 Star Ratings. To calculate the CAI, case-mix adjustment is applied to all clinical Star Rating measure scores that are not adjusted for SES using a beneficiary-level logistic regression model with contract fixed effects and beneficiary-level indicators of LIS/DE and disability status, similar to the approach currently used to adjust CAHPS patient experience measures. However, unlike CAHPS case-mix adjustment, the only adjusters are LIS/DE and disability status. Adjusted measure scores are then converted to measure stars using the 2023 rating year measure cutoffs and used to calculate Adjusted Overall and Summary Star Ratings. Unadjusted Overall and Summary Star Ratings are also determined for each contract.

The 2023 measures used in the 2024 CAI adjustment calculations are:

- Breast Cancer Screening (Part C)
- Colorectal Cancer Screening (Part C)
- Annual Flu Vaccine (Part C)
- Monitoring Physical Activity (Part C)
- Osteoporosis Management in Women who had a Fracture (Part C)
- Diabetes Care – Eye Exam (Part C)
- Diabetes Care – Blood Sugar Controlled (Part C)
- Controlling Blood Pressure (Part C)
- Reducing the Risk of Falling (Part C)
- Improving Bladder Control (Part C)
- Medication Reconciliation Post-Discharge (Part C)
- Statin Therapy for Patients with Cardiovascular Disease (Part C)
- Medication Adherence for Diabetes Medication (Part D)
- Medication Adherence for Hypertension (RAS antagonists) (Part D)
- Medication Adherence for Cholesterol (Statins) (Part D)
- MTM Program Completion Rate for CMR (Part D)
- Statin Use in Patients with Diabetes (SUPD) (Part D)

To determine the value of the CAI, contracts are first divided into an initial set of categories based on the combination of a contract's LIS/DE and disability percentages. For the adjustment for the overall and summary ratings for MA-Only and MA-PD contracts, the initial groups are formed by the ten groups of LIS/DE and quintiles of disability, thus resulting in 50 initial categories. For PDPs, the initial groups are formed using quintiles for both LIS/DE and disability. The mean differences between the Adjusted Overall or Summary Star Rating and the corresponding Unadjusted Star Rating for contracts in each initial category are determined and examined. The initial categories are collapsed to form final adjustment groups. The CAI values are the mean differences between the Adjusted Overall or Summary Star Rating and the corresponding Unadjusted Star Rating for contracts within each final adjustment group. Separate CAI values are computed for the overall and summary

ratings, and the rating-specific CAI value is the same for all contracts that fall within the same final adjustment category.

The categorization of contracts into final adjustment categories for the CAI relies on both the use of a contract's percentages of LIS/DE and disabled beneficiaries. Categories were chosen to enforce monotonicity and to yield a minimum number of 30 contracts per each final MA adjustment category and 5 contracts per each final PDP adjustment category. Puerto Rico has a unique health care market with a large percentage of low-income individuals in both Medicare and Medicaid and a complex legal history that affects the health care system in many ways. Puerto Rican beneficiaries are not eligible for LIS. Since the percentage of LIS/DE is a critical element in the categorization of contracts to identify the contract's CAI, an additional adjustment is done for contracts that solely serve the population of beneficiaries in Puerto Rico to address the lack of LIS. The additional analysis for the adjustment results in a modified percentage of LIS/DE beneficiaries that is subsequently used to categorize the contract in its final adjustment category for the CAI. Details regarding the methodology for the Puerto Rico model are provided in Attachment O.

Tables 10 and 11 provide the range of the percentages that correspond to the LIS/DE initial groups and disability quintiles for the determination of the CAI values for the Overall Rating. For example, if a contract's percentage of LIS/DE beneficiaries is 13.60%, the contract's LIS/DE initial group would be L4. The upper limit for each initial category is only included for the highest categories (L10 and D5), and the upper limit is equal to 100% for both of these categories.

Table 10: Categorization of Contract's Members into LIS/DE Initial Groups for the Overall Rating

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 6.301653
2	6.301653 to less than 8.983864
3	8.983864 to less than 12.272291
4	12.272291 to less than 17.623062
5	17.623062 to less than 23.811644
6	23.811644 to less than 32.478787
7	32.478787 to less than 48.171334
8	48.171334 to less than 76.744186
9	76.744186 to less than 100.000000
10	100.000000

Table 11: Categorization of Contract's Members into Disability Quintiles for the Overall Rating

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 15.246926
2	15.246926 to less than 22.226124
3	22.226124 to less than 29.541446
4	29.541446 to less than 43.095797
5	43.095797 to 100.000000

Table 12 provides the description of each of the final adjustment categories and the associated value of the CAI per category for the overall rating.

Table 12: Final Adjustment Categories and CAI Values for the Overall Rating

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1 - L3	D1	-0.024917
2	L4-L10 L1-L10 L1-L4	D1 D2 D3	-0.001531
3	L5-L6 L1-L6	D3 D4-D5	0.016703
4	L7-L9 L7-L8 L7	D3 D4 D5	0.036199
5	L8	D5	0.067616
6	L10 L9-L10 L9	D3 D4 D5	0.087672
7	L10	D5	0.133273

Tables 13 and 14 provide the range of the percentages that correspond to the LIS/DE initial groups and disability quintiles for the initial categories for the determination of the CAI values for the Part C summary.

Table 13: Categorization of Contract's Members into LIS/DE Initial Groups for the Part C Summary

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 5.758017
2	5.758017 to less than 8.524590
3	8.524590 to less than 11.765670
4	11.765670 to less than 17.215998
5	17.215998 to less than 23.365002
6	23.365002 to less than 31.600120
7	31.600120 to less than 46.717818
8	46.717818 to less than 74.752781
9	74.752781 to less than 100.000000
10	100.000000

Table 14: Categorization of Contract's Members into Disability Quintiles for the Part C Summary

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 14.974530
2	14.974530 to less than 21.948529
3	21.948529 to less than 29.414572
4	29.414572 to less than 42.395693
5	42.395693 to 100.000000

Table 15 provides the description of each of the final adjustment categories for the Part C summary and the associated value of the CAI for each final adjustment category.

Table 15: Final Adjustment Categories and CAI Values for the Part C Summary

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1-L7 L1-L6 L1-L5 L1-L4	D1 D2 D3 D4	-0.003487
2	L8-L10 L7-L10 L6-L7 L5-L6 L1-L5	D1 D2 D3 D4 D5	0.006987
3	L8-L10 L7-L8 L6-L7	D3 D4 D5	0.022797
4	L8	D5	0.044588
5	L9-L10	D4-D5	0.066880

Tables 16 and 17 provide the range of the percentages that correspond to the LIS/DE initial groups and the disability quintiles for the initial categories for the determination of the CAI values for the Part D summary rating for MA-PDs.

Table 16: Categorization of Contract's Members into LIS/DE Initial Groups for the MA-PD Part D Summary

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 6.507512
2	6.507512 to less than 9.702347
3	9.702347 to less than 13.812027
4	13.812027 to less than 19.485294
5	19.485294 to less than 26.769231
6	26.769231 to less than 38.003026
7	38.003026 to less than 58.059701
8	58.059701 to less than 93.000000
9	93.000000 to less than 100.000000
10	100.000000

Table 17: Categorization of Contract's Members into Disability Quintiles for the MA-PD Part D Summary

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 15.588308
2	15.588308 to less than 23.253251
3	23.253251 to less than 32.385819
4	32.385819 to less than 46.047270
5	46.047270 to 100.000000

Table 18 provides the description of each of the final adjustment categories for the MA-PD Part D summary and the associated values of the CAI for each final adjustment category.

Table 18: Final Adjustment Categories and CAI Values for the MA-PD Part D Summary

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1-L3	D1	-0.035219
2	L4-L8 L1-L7	D1 D2	-0.018599
3	L1-L6 L1-L5	D3 D4-D5	0.009901
4	L9 L8-L9 L7-L8 L6-L7 L6	D1 D2 D3 D4 D5	0.034454
5	L8 L7-L8	D4 D5	0.079744
6	L10 L9	D1-D4 D3-D5	0.110538
7	L10	D5	0.124667

Tables 19 and 20 provide the range of the percentages that correspond to the LIS/DE and disability quintiles for the initial categories for the determination of the CAI values for the PDP Part D summary. Quintiles are used for both dimensions due to the limited number of PDPs as compared to MA-PD contracts.

Table 19: Categorization of Contract's Members into Quintiles of LIS/DE for the PDP Part D Summary

LIS/DE Quintile	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 1.243781
2	1.243781 to less than 2.398356
3	2.398356 to less than 4.421104
4	4.421104 to less than 10.174281
5	10.174281 to 100.000000

Table 20: Categorization of Contract's Members into Quintiles of Disability for the PDP Part D Summary

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 6.154784
2	6.154784 to less than 8.398344
3	8.398344 to less than 11.264808
4	11.264808 to less than 15.616311
5	15.616311 to 100.000000

Table 21 provides the description of each of the final adjustment categories for the PDP Part D summary and the associated value of the CAI per final adjustment category. Note that the CAI values for the PDP Part D summary are different from the CAI values for the MA-PD Part D summary. There are five final adjustment categories for the PDP Part D summary.

Table 21: Final Adjustment Categories and CAI Values for the PDP Part D Summary

Final Adjustment Category	LIS/DE Quintile	Disability Quintile	CAI Value
1	L1	D1	-0.317950
2	L2 L1-L2	D1 D2	-0.172794
3	L3-L5 L1-L3 L1	D1-D2 D3 D4	-0.139296
4	L4-L5 L2-L5 L1-L4	D3 D4 D5	-0.067530
5	L5	D5	0.043919

Calculation Precision

CMS and its contractors have always used software called SAS (an integrated system of software products provided by SAS Institute Inc.) to perform the calculations used in producing the Star Ratings. For all measures, except the improvement measures, the precision used in scoring the measure is indicated next to the label "Data Display" within the detailed description of each measure. The improvement measures are discussed below. The domain ratings are the unweighted average of the star measures and are rounded to the nearest integer.
The improvement measures, summary, and overall ratings are calculated with at least six digits of precision after the decimal whenever the data allow it. The HEDIS measure scores have two digits of precision after the decimal. All other measures have at least six digits of precision when used in the improvement calculation.

Contracts may request a contract-specific calculation spreadsheet which emulates the actual SAS calculations from the Star Ratings mailbox during the second plan preview.

It is not possible to replicate CMS's calculations exactly due to factors including, but not limited to: using published measure data from sources other than CMS's Star Rating program which use different rounding rules, and exclusion of some contracts' ratings from publicly-posted data (e.g., terminated contracts).

Rounding Rules for Measure Scores

Measure scores are rounded to the precision indicated next to the label "Data Display" within the detailed description of each measure. Measure scores are rounded using traditional rounding rules. These are standard "round to nearest" rules prior to cut point analysis. To obtain a value with the specified level of precision, the single digit following the level of precision will be rounded. If the digit to be rounded is 0, 1, 2, 3 or 4, the value is rounded down, with no adjustment to the preceding digit. If the digit to be rounded is 5, 6, 7, 8 or 9, the value is rounded up, and a value of one is added to the preceding digit. After rounding, all digits after the specified level of precision are removed. If rounding to a whole number, the digit to be rounded is in the first decimal place. If the digit in the first decimal place is below 5, then after rounding the whole number remains unchanged and fractional parts of the number are deleted. If the digit in the first decimal place is 5 or greater, then the whole number is rounded up by adding a value of 1 and fractional parts of the number are deleted. For example, a measure listed with a Data Display of "Percentage with no decimal point" that has a value of 83.499999 rounds down to 83, while a value of 83.500000 rounds up to 84.

Rounding Rules for Summary and Overall Ratings

The results of the summary and overall calculations are rounded to the nearest half star (i.e., 0.5, 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, 5.0). Table 22 summarizes the rounding rules for converting the Part C and D summary and overall ratings into the publicly reported Star Ratings.

Table 22: Rounding Rules for Summary and Overall Ratings

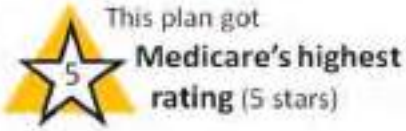
Raw Summary / Overall Score	Final Summary / Overall Rating
0.000000 to less than 0.250000	0
0.250000 to less than 0.750000	0.5
0.750000 to less than 1.250000	1.0
1.250000 to less than 1.750000	1.5
1.750000 to less than2.250000	2.0
2.250000 to less than2.750000	2.5
2.750000 to less than3.250000	3.0
3.250000 to less than 3.750000	3.5
3.750000 to less than 4.250000	4.0
4.250000 to less than 4.750000	4.5
4.750000 to 5.000000	5.0

For example, a summary or overall rating of 3.749999 rounds down to a rating of 3.5, and a rating of 3.750000 rounds up to rating of 4. That is, a score would need to be at least halfway between 3.5 and 4 (having a minimum value of 3.750000) in order to obtain the higher rating of 4.

Methodology for Calculating the High Performing Icon

A contract may receive a high performing icon as a result of its performance on the Parts C and/or D measures. The high performing icon is assigned to an MA-Only contract for achieving a 5-star Part C summary rating, a PDP contract for a 5-star Part D summary rating, and an MA-PD contract for a 5-star overall rating. Figure 3 shows the high performing icon used in the MPF:

Figure 3: The High Performing Icon



Methodology for Calculating the Low Performing Icon

A contract can receive a low performing icon as a result of its performance on the Part C and/or Part D summary ratings. The low performing icon is calculated by evaluating the Part C and Part D summary ratings for the current year and the past two years (i.e., the 2022, 2023, and 2024 Star Ratings). If the contract had any combination of Part C and/or Part D summary ratings of 2.5 or lower in all three years of data, it is marked with a low performing icon (LPI). A contract must have a rating in either Part C and/or Part D for all three years to be considered for this icon.

Figure 4 shows the low performing contract icon used in the MPF:

Figure 4: The Low Performing Icon

Table 23 shows example contracts which would receive an LPI.

Table 23: Example LPI Contracts

Contract/Rating	Rated As	2022 C	2023 C	2024 C	2022 D	2023 D	2024 D	LPI Awarded	LPI Reason
HAAAA	MA-PD	2	2.5	2.5	3	3	3	Yes	Part C
HBBBB	MA-PD	3	3	3	2.5	2	2.5	Yes	Part D
HCCCC	MA-PD	2.5	3	3	3	2.5	2.5	Yes	Part C or D
HDDDD	MA-PD	3	2.5	3	2.5	3	2.5	Yes	Part C or D
HEEEE	MA-PD	2.5	2	2.5	2	2.5	2.5	Yes	Part C and D
HFFFF	MA-Only	2.5	2	2.5	-	-	-	Yes	Part C
SAAAA	PDP	-	-	-	2.5	2.5	2	Yes	Part D

Mergers, Novations, and Consolidations

This section covers how the Star Ratings are affected by mergers, novation and consolidations. To ensure a common understanding, we begin by defining each of the terms.

- Merger: when two (or more) companies join together to become a single business. Each of these separate businesses had one or more contracts with CMS for offering health and/or drug services to Medicare beneficiaries. After the merger, all of those individual contracts with CMS are still intact, only the ownership changes in each of the contracts to the name of the new single business. Mergers can occur at any time during a contract year.
- Novation: when one company acquires another company. Each of these separate businesses had one or more contracts with CMS for offering health and/or drug services to beneficiaries. After the novation, all of those individual contracts with CMS are still intact. The owner's names of the contracts acquired are changed to the new owner's name. Novations can occur at any time during the contract year.
- Consolidation: when an organization/sponsor that has at least two contracts with CMS for offering health and/or drug services to beneficiaries combines multiple contracts into a single contract with CMS. Consolidations occur

only at the change of the contract year. The one or more contracts that will no longer exist at contract year's end are known as the consumed contracts. The contract that will still exist is known as the surviving contract and all of the beneficiaries still enrolled in the consumed contract(s) are moved to the surviving contract.

Mergers and novations do not change the ratings earned by an individual contract in any way.

For a merger or novation, the only change is the company listed as owning the contract; there is no change in contract structure, so the Star Ratings earned by the contract remains with them until the next rating cycle. This includes any High Performing or Low Performing icons earned by any of the contracts.

Consolidations become effective the first day of the calendar year. The Star Ratings are released the previous October, so they are available when open enrollment begins. In the first year following a consolidation, the measure values used in calculating the Star Ratings of the surviving contract will be based on the enrollment-weighted mean of all contracts in the consolidation (see Attachment B). The surviving contract's ratings are posted publicly, used in determining QBP ratings, and included in the Past Performance Analysis.

Reliability Requirement for Low-enrollment Contracts

HEDIS measures for contracts whose enrollment as of July 2022 was at least 500 but less than 1,000 will be included in the Star Ratings in 2024 when the contract-specific measure score reliability is equal to or greater than 0.7. The reliability calculations are implemented using SAS PROC MIXED as documented on pages 31-32 of the report "The Reliability of Provider Profiling – A Tutorial," available at https://www.rand.org/pubs/technical_reports/TR653.html.

The within-contract variance for the Transitions of Care composite measure utilizes a different formula than other HEDIS pass/fail measures because it is an average of four component measures. First, the binomial variances and standard deviations (i.e., the square root of a variance term), as discussed in the report "The Reliability of Provider Profiling – A Tutorial", are calculated for each of the four component measures. Next, pairwise correlations are computed among the four component measures. Pairwise covariance terms among the four component measures are calculated by multiplying the respective pairwise correlation and two items' standard deviations together. The final within-contract variance for the Transitions of Care composite measure is computed by summing the four variance terms and each pairwise covariance term multiplied by 2.0.

Special Needs Plan (SNP) Data

A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limits enrollment to special needs individuals. There are three major types of SNPs: 1) Chronic Condition SNP (C-SNP), 2) Dual Eligible SNP (D-SNP), and 3) Institutional SNP (I-SNP). Further details on SNP plans can be found in the glossary, Attachment R.

CMS has included three SNP-specific measures in the 2024 Star Ratings. The Part C 'Special Needs Plan Care Management' measure is based on data reported by contracts through the Medicare Part C Reporting Requirements. The two Part C 'Care for Older Adults' measures are based on HEDIS data. The data for all of these measures are reported at the plan benefit package (PBP) level, while the Star Ratings are reported at the contract level.

The methodology used to combine the PBP data to the contract level is different between the two data sources. The Part C Reporting Requirements data are summed into a contract-level rate after excluding PBPs that do not map to any PBP offered by the contract in the calendar year for which the Reporting Requirements data underwent data validation. The HEDIS data are summed into a contract-level rate as long as the contract will be offering a SNP PBP in the Star Ratings year.

The two methodologies used to combine the PBP data within a contract for these measures are described further in Attachment E.

Star Ratings and Marketing

Plan sponsors must ensure the Star Ratings document and all marketing of Star Ratings information is compliant with CMS's Medicare Marketing Guidelines. Failure to follow CMS' guidance may result in compliance action against the contract. The Medicare Marketing Guidelines were issued as Chapters 2 and 3 of the Prescription Drug Benefit Manual and the Medicare Managed Care Manual, respectively. Please direct questions about marketing Star Ratings information to your Account Manager.

Contact Information

The contact below can assist you with various aspects of the Star Ratings.

- Part C & D Star Ratings: PartCandDStarRatings@cms.hhs.gov

If you have questions or require information about the specific subject areas associated with the Star Ratings please write to those contacts directly and cc the Part C & D Star Ratings mailbox.

- CAHPS (MA & Part D): MP-CAHPS@cms.hhs.gov
- Call Center Monitoring: CallCenterMonitoring@cms.hhs.gov
- Compliance Activity Module issues (Part C): PartCCompliance@cms.hhs.gov
- Compliance Activity Module issues (Part D): PartD_Monitoring@cms.hhs.gov
- Demonstration (Medicare-Medicaid Plan) Ratings: mmcocapsmodel@cms.hhs.gov
- Disenrollment Reasons Survey: DisenrollSurvey@cms.hhs.gov
- HEDIS: HEDISquestions@cms.hhs.gov
- HOS: HOS@cms.hhs.gov
- HPMS Access issues: CMSHPMS_Access@cms.hhs.gov
- HPMS Help Desk (all other HPMS issues): HPMS@cms.hhs.gov
- Marketing: marketing@cms.hhs.gov
- Part C Compliance Activity issues: PartCCompliance@cms.hhs.gov
- Part D Compliance Activity issues: PartD_Monitoring@cms.hhs.gov
- Plan Reporting (Part C): Partcplanreporting@cms.hhs.gov
- Plan Reporting (Part D): Partd-planreporting@cms.hhs.gov
- Plan Reporting Data Validation (Part C & D): PartCandD_Data_Validation@cms.hhs.gov
- QBP Ratings and Appeals questions: QBPAppeals@cms.hhs.gov
- QBP Payment or Risk Analysis questions: riskadjustment@cms.hhs.gov

Framework and Definitions for the Domain and Measure Details Section

This page contains the formatting framework and definition of each sub-section that is used to describe the domain and measure details on the following pages.

Domain: The name of the domain to which the measures following this heading belong

Measure: The measure ID and common name of the ratings measure

Title	Description
Label for Stars:	The label that appears with the stars for this measure on Medicare.gov.
Label for Data:	The label that appears with the numeric data for this measure on HPMS and CMS.gov.
Description:	The English language description shown for the measure on Medicare.gov. The text in this sub-section has been prepared to aid beneficiaries' understanding of the nature and the purpose of the measure. We strongly encourage any public-facing explanation of the measure to use this description.
HEDIS Label:	Optional – contains the full NCQA HEDIS measure name.
Measure Reference:	Optional – this sub-section contains the location of the detailed measure specification in the NCQA documentation for all HEDIS and HEDIS-HOS measures.
Metric:	Defines how the measure is calculated.
Primary Data Source:	The primary source of the data used in the measure.
Data Source Description:	Optional – contains information about additional data sources needed for calculating the measure.
Data Source Category:	The category of this data source.
Exclusions:	Optional – lists any exclusions applied to the data used for the measure.
General Notes:	Optional – contains additional information about the measure and the data used.
Data Time Frame:	The time frame of data used from the data source. In some HEDIS measures this date range may appear to conflict with the specific data time frame defined in the NCQA Technical Specifications. In those cases, the data used by CMS are unchanged from what was submitted to NCQA. CMS uses the data time frame of the overall HEDIS submission which is the HEDIS measurement year.
General Trend:	Indicates whether high values are better or low values are better for the measure.
Statistical Method:	The methodology used for assigning stars in this measure; see the section entitled "Methodology for Assigning Part C and Part D Measure Star Ratings" for an explanation of each of the possible entries in this sub-section.
Improvement Measure:	Indicates whether this measure is included in the improvement measure.
CAI Usage:	Indicates if the measure is used in the Categorical Adjustment Index calculation.
Case-Mix Adjusted:	Indicates if the data are case mix adjusted prior to being used for the Star Ratings.
Weighting Category:	The weighting category of this measure.

Title	Description
Weighting Value:	The numeric weight for this measure in the summary and overall rating calculations.
Meaningful Measure Area:	Contains the area where this measure fits into the Meaningful Measure Framework.
CMIT #:	The CMS Measure Inventory Tool (CMIT) is the repository of record for information about the measures which CMS uses to promote healthcare quality and quality improvement.
Data Display:	The format used to the display the numeric data on Medicare.gov
Reporting Requirements:	Table indicating which organization types are required to report the measure. "Yes" for organizations required to report; "No" for organizations not required to report.
Cut Points:	Table containing the cut points used in the measure. For non-CAHPS measures, excluding new measures or measures with substantive specification changes for the first three years, the cut points are after the application of Tukey outlier deletion, mean resampling, and guardrails. The Health Plan Quality Improvement and Drug Plan Quality Improvement measure cut points are after the application of Tukey outlier deletion and mean resampling. For CAHPS measures, the table contains the base group cut points which are used prior to the final star assignment rules being applied.

Part C Domain and Measure Details

See Attachment C for the national averages of individual Part C measures.

Domain: 1 - Staying Healthy: Screenings, Tests and Vaccines

Measure: C01 - Breast Cancer Screening

Title	Description
Label for Stars:	Breast Cancer Screening
Label for Data:	Breast Cancer Screening
Description:	Percent of female plan members aged 52-74 who had a mammogram during the past two years.
HEDIS Label:	Breast Cancer Screening (BCS)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 95
Metric:	The percentage of women MA enrollees 50 to 74 years of age (denominator) as of December 31 of the measurement year who had a mammogram to screen for breast cancer in the past two years(numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans

Exclusions:

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria:
  - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits.
  - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
  - A dispensed dementia medication (Dementia Medications List).
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set)

Title	Description
	during the measurement year (optional) Bilateral mastectomy any time during the member's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy: • Bilateral mastectomy (Bilateral Mastectomy Value Set). • Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set). • Two unilateral mastectomies (Unilateral Mastectomy Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1 of the measurement year, the service date for the second unilateral mastectomy must be on or after February 15. • Both of the following (on the same or a different date of service): – Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Right Modifier Value Set) (same date of service). – Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) (same date of service). • Absence of the left breast (Absence of Left Breast Value Set) and absence of the right breast (Absence of Right Breast Value Set) on the same or different date of service. • History of bilateral mastectomy (History of Bilateral Mastectomy Value Set). • Left unilateral mastectomy (Unilateral Mastectomy Left Value Set) and right unilateral mastectomy (Unilateral Mastectomy Right Value Set) on the same or different date of service.
	Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1

Title	Description
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00093-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 52%	52% to less than 63%	63% to less than 71%	71% to less than 79%	greater than or equal to 79%

Measure: C02 - Colorectal Cancer Screening

Title	Description
Label for Stars:	Colorectal Cancer Screening
Label for Data:	Colorectal Cancer Screening
Description:	Percent of plan members aged 50-75 who had appropriate screening for colon cancer.
HEDIS Label:	Colorectal Cancer Screening (COL)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 105
Metric:	The percentage of MA enrollees aged 50 to 75 (denominator) as of December 31 of the measurement year who had appropriate screenings for colorectal cancer (numerator).
Primary Data Source:	HEDIS Patient-level Data
Data Source Category:	Health and Drug Plans

Exclusions:

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year (optional) Refer to Administrative Specification for

Title	Description
	exclusion criteria. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year.
	Contracts whose enrollment was at least 500 but less than 1,000 as of the enrollment report and having measure score reliability less than 0.7 are excluded.
	Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00139-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 50%	50% to less than 61%	61% to less than 71%	71% to less than 80%	greater than or equal to 80%

Measure: C03 - Annual Flu Vaccine

Title	Description
Label for Stars:	Yearly Flu Vaccine
Label for Data:	Yearly Flu Vaccine

Title	Description

Description: Percent of plan members who got a vaccine (flu shot).

Metric: The percentage of sampled Medicare enrollees (denominator) who received an influenza vaccination (numerator).

Primary Data Source: CAHPS

Data Source Description: CAHPS Survey Question (question number varies depending on survey type):

- Have you had a flu shot since July 1, 2022?

Data Source Category: Survey of Enrollees

General Notes: This measure is not case-mix adjusted.

CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2023 – 06/2023

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Wellness and Prevention

CMIT #: 00259-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 63%	63% to less than 67%	67% to less than 74%	74% to less than 78%	greater than or equal to78%

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C04 - Monitoring Physical Activity

Title	Description
Label for Stars:	Monitoring Physical Activity
Label for Data:	Monitoring Physical Activity
Description:	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase, or maintain their physical activity during the year.
HEDIS Label:	Physical Activity in Older Adults (PAO)
Measure Reference:	NCQA HEDIS Measurement Year 2021 Specifications for the Medicare Health Outcomes Survey Volume 6, page 37
Metric:	The percentage of sampled Medicare members 65 years of age or older who had a doctor's visit in the past 12 months (denominator) and who received advice to start, increase or maintain their level exercise or physical activity (numerator).
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 23 Follow-up Data collection (2022) and Cohort 25 Baseline data collection (2022). HOS Survey Question 42: In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise. HOS Survey Question 43: In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.
Data Source Category:	Survey of Enrollees
Exclusions:	Members who responded "I had no visits in the past 12 months" to Question 42 are excluded from results calculations for Question 43. Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded.
Data Time Frame:	07/19/2022 – 11/01/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included

Title	Description

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2021 disasters.

Meaningful Measure Area: Wellness and Prevention

CMIT #: 00540-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 42%	42% to less than 48%	48% to less than 53%	53% to less than 58%	greater than or equal to 58%

Domain: 2 - Managing Chronic (Long Term) Conditions

Measure: C05 - Special Needs Plan (SNP) Care Management

Title	Description
Label for Stars:	Members Whose Plan Did an Assessment of Their Health Needs and Risks
Label for Data:	Members Whose Plan Did an Assessment of Their Health Needs and Risks
Description:	Percent of members whose plan did an assessment of their health needs and risks in the past year. The results of this review are used to help the member get the care they need. (Medicare does not collect this information from all plans. Medicare collects it only for Special Needs Plans. These plans are a type of Medicare Advantage plan designed for certain people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)
Metric:	This measure is defined as the percent of eligible Special Needs Plan (SNP) enrollees who received a health risk assessment (HRA) during the measurement year. The denominator for this measure is the sum of the number of new enrollees due for an Initial HRA (Element A) and the number of enrollees eligible for an annual reassessment HRA (Element B). The numerator for this measure is the sum of the number of initial HRAs performed on new enrollees (Element C) and the number of annual reassessments performed on enrollees eligible for a reassessment (Element F). The equation for calculating the SNP Care Management Assessment Rate is: [Number of initial HRAs performed on new enrollees (Element C) + Number of annual reassessments performed on enrollees eligible for a reassessment (Element F)] / [Number of new enrollees due for an Initial HRA (Element A) + Number of enrollees eligible for an annual reassessment HRA (Element B)]
Primary Data Source:	Part C Plan Reporting
Data Source Description:	Data reported by contracts to CMS per the Part C Reporting Requirements. Validation for data performed during the 2023 Data Validation cycle.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts and PBPs with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2023) are excluded and listed as "No data available." SNP Care Management Assessment Rates are not provided for contracts that did not score at least 95% on data validation for the SNP Care Management reporting section or were not compliant with data validation standards/sub-standards for any of the following SNP Care Management data elements: • Number of new enrollees due for an initial HRA (Element A) • Number of enrollees eligible for an annual reassessment HRA (Element B) • Number of initial HRAs performed on new enrollees (Element C)

Title	Description
	• Number of annual reassessments performed on enrollees eligible for reassessment (Element F) Contracts excluded from the SNP Care Management Assessment Rates due to data validation issues are shown as "CMS identified issues with this plan's data." Contracts can view their data validation results in HPMS (https://hpms.cms.gov/). To access this page, from the top menu select "Monitoring," then "Plan Reporting Data Validation." Select the appropriate contract year. Select the PRDVM Reports. Select "Score Detail Report." Select the applicable reporting section. If you cannot see the Plan Reporting Data Validation module, contact CMSHPMS_Access@cms.hhs.gov. Additionally, contracts must have 30 or more enrollees in the denominator [Number of new enrollees due for an Initial HRA (Element A) + Number of enrollees eligible for an annual HRA (Element B) ≥ 30] in order to have a calculated rate. Contracts with fewer than 30 eligible enrollees are listed as "No data available."
General Notes:	More information about the data used to calculate this measure can be found in Attachment E. The Part C reporting requirement fields listed below are not used in calculating this measure: • Data Element D Number of initial HRA refusals • Data Element E Number of initial HRAs where SNP is unable to reach new enrollees • Data Element G Number of annual reassessment refusals • Data Element H Number of annual reassessments where SNP is unable to reach enrollee
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Title	Description

Meaningful Measure Area: Chronic Conditions

CMIT #: 00685-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	No	Yes	Yes	No	No	No

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 42%	42% to less than 57%	57% to less than 74%	74% to less than 85%	greater than or equal to 85%

Measure: C06 - Care for Older Adults – Medication Review

Title	Description
Label for Stars:	Yearly Review of All Medications and Supplements Being Taken
Label for Data:	Yearly Review of All Medications and Supplements Being Taken
Description:	Percent of plan members whose doctor or clinical pharmacist reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year. (Medicare does not collect this information from all plans. Medicare collects it only for Special Needs Plans. These plans are a type of Medicare Advantage plan designed for certain people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)
HEDIS Label:	Care for Older Adults (COA) – Medication Review
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 118
Metric:	The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Medication List Value Set) (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	SNP benefit packages whose enrollment was less than 30 as of February 2022 SNP Comprehensive Report were excluded from this measure.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1

Title	Description
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00110-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	No	Yes	Yes	No	No	No

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 72%	72% to less than 84%	84% to less than 93%	93% to less than 98%	greater than or equal to 98%

Measure: C07 - Care for Older Adults – Pain Assessment

Title	Description
Label for Stars:	Yearly Pain Screening or Pain Management Plan
Label for Data:	Yearly Pain Screening or Pain Management Plan
Description:	Percent of plan members who had a pain screening at least once during the year. (Medicare does not collect this information from all plans. Medicare collects it only for Special Needs Plans. These plans are a type of Medicare Advantage plan designed for certain people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)
HEDIS Label:	Care for Older Adults (COA) – Pain Screening
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 118
Metric:	The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one pain assessment (Pain Assessment Value Set) plan during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	SNP benefit packages whose enrollment was less than 30 as of February 2022 SNP Comprehensive Report were excluded from this measure.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00111-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	No	Yes	Yes	No	No	No

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 74%	74% to less than 83%	83% to less than 91%	91% to less than 96%	greater than or equal to 96%

Measure: C08 - Osteoporosis Management in Women who had a Fracture

Title	Description
Label for Stars:	Osteoporosis Management
Label for Data:	Osteoporosis Management
Description:	Percent of female plan members who broke a bone and got screening or treatment for osteoporosis within 6 months.
HEDIS Label:	Osteoporosis Management in Women Who Had a Fracture (OMW)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 228
Metric:	The percentage of woman MA enrollees 67 - 85 who suffered a fracture (denominator) and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans

Title	Description

Exclusions:

- Members who had a BMD test (Bone Mineral Density Tests Value Set) during the 730 days (24 months) prior to the IESD.
- Members who had a claim/encounter for osteoporosis therapy (Osteoporosis Medications Value Set) during the 365 days (12 months) prior to the IESD.
- Members who received a dispensed prescription or had an active prescription to treat osteoporosis (Osteoporosis Medications List) during the 365 days (12 months) prior to the IESD.
- Members who are enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
- Members living long-term in an institution any time during the measurement year.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2022 – 12/31/2022

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00484-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars

Title	Description				
	less than 29%	29% to less than 42%	42% to less than 55%	55% to less than 71%	greater than or equal to 71%

Measure: C09 - Diabetes Care – Eye Exam

Title	Description
Label for Stars:	Eye Exam to Check for Damage from Diabetes
Label for Data:	Eye Exam to Check for Damage from Diabetes
Description:	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.
HEDIS Label:	Eye Exam for Patients with Diabetes (EED)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 203
Metric:	The percentage of diabetic MA enrollees age 18-75 with diabetes (type 1 and type 2) (denominator) who had an eye exam (retinal) performed during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with both frailty (Frailty Value Set) and advanced illness (Advanced Illness Value Set) during the measurement year. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same.

Title	Description
	If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00203-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 52%	52% to less than 65%	65% to less than 73%	73% to less than 81%	greater than or equal to 81%

Measure: C10 - Diabetes Care – Blood Sugar Controlled

Title	Description
Label for Stars:	Plan Members with Diabetes whose Blood Sugar is Under Control
Label for Data:	Plan Members with Diabetes whose Blood Sugar is Under Control

Title	Description
Description:	Percent of plan members with diabetes who had an A1c lab test during the year that showed their average blood sugar is under control.
HEDIS Label:	Hemoglobin A1c Control for Patients with Diabetes (HBD) – HbA1c poor control (>9.0%)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 184
Metric:	The percentage of diabetic MA enrollees age 18-75 (denominator) whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year (numerator). (This measure for public reporting is reverse scored so higher scores are better.) To calculate this measure, subtract the submitted rate from 100.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with both frailty (Frailty Value Set) and advanced illness (Advanced Illness Value Set) during the measurement year. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same. If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022

Title	Description
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00204-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 58%	58% to less than 72%	72% to less than 80%	80% to less than 87%	greater than or equal to 87%

Measure: C11 - Controlling Blood Pressure

Title	Description
Label for Stars:	Controlling Blood Pressure
Label for Data:	Controlling Blood Pressure
Description:	Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure.
HEDIS Label:	Controlling High Blood Pressure (CBP)
Measure Reference:	NCQA HEDIS MY 2022 Technical Specifications Volume 2, page 152
Metric:	The percentage of MA members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose BP was adequately controlled (<140/90 mm Hg) (numerator).
Primary Data Source:	HEDIS

Title	Description
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude members who meet any of the following criteria: • Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 81 years of age and older as of December 31 of the measurement year with frailty (Frailty Value Set) during the measurement year. • Members 66–80 years of age and older as of December 31 of the measurement year with frailty (Frailty Value Set) and advanced illness during the measurement year. • A dispensed dementia medication. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. (Optional) • Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis. • Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. • Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcomes Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00167-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 58%	58% to less than 68%	68% to less than 74%	74% to less than 82%	greater than or equal to 82%

Measure: C12 - Reducing the Risk of Falling

Title	Description
Label for Stars:	Reducing the Risk of Falling
Label for Data:	Reducing the Risk of Falling
Description:	Percent of plan members with a problem falling, walking, or balancing who discussed it with their doctor and received a recommendation for how to prevent falls during the year.
HEDIS Label:	Fall Risk Management (FRM)
Measure Reference:	NCQA HEDIS Measurement Year 2021 Specifications for the Medicare Health Outcomes Survey Volume 6, page 39
Metric:	The percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months (denominator) and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner (numerator).

Title	Description
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 23 Follow-up Data collection (2022) and Cohort 25 Baseline data collection (2022). HOS Survey Question 44: A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? HOS Survey Question 45: Did you fall in the past 12 months? HOS Survey Question 46: In the past 12 months have you had a problem with balance or walking? HOS Survey Question 47: Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include: • Suggest that you use a cane or walker. • Suggest that you do an exercise or physical therapy program. • Suggest a vision or hearing test.
Data Source Category:	Survey of Enrollees
Exclusions:	Members who responded "I had no visits in the past 12 months" to Question 44 or Question 47 are excluded from results calculations. Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded.
Data Time Frame:	07/19/2022 – 11/01/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Safety

Title	Description
CMIT #:	00646-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 47%	47% to less than 53%	53% to less than 60%	60% to less than 70%	greater than or equal to 70%

Measure: C13 - Improving Bladder Control

Title	Description
Label for Stars:	Improving Bladder Control
Label for Data:	Improving Bladder Control
Description:	Percent of plan members with a urine leakage problem in the past 6 months who discussed treatment options with a provider.
HEDIS Label:	Management of Urinary Incontinence in Older Adults (MUI)
Measure Reference:	NCQA HEDIS Measurement Year 2021 Specifications for the Medicare Health Outcomes Survey Volume 6, page 34
Metric:	The percentage of Medicare members 65 years of age or older who reported having any urine leakage in the past six months (denominator) and who discussed treatment options for their urinary incontinence with a provider (numerator).
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 23 Follow-up Data collection (2022) and Cohort 25 Baseline data collection (2022). HOS Survey Question 38: Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? HOS Survey Question 41: There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches? Member choices must be as follows to be included in the denominator: • Q38 = "Yes." • Q41 = "Yes" or "No." The numerator contains the number of members in the denominator who indicated they discussed treatment options for their urinary incontinence with a health care provider. Member choice must be as follows to be included in the numerator:

Title	Description

- Q41 = "Yes."

Data Source Category: Survey of Enrollees

Exclusions: Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded.

Data Time Frame: 07/19/2022 – 11/01/2022

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2021 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00378-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 38%	38% to less than 42%	42% to less than 47%	47% to less than 51%	greater than or equal to 51%

Measure: C14 - Medication Reconciliation Post-Discharge

Title	Description
Label for Stars:	The Plan Makes Sure Member Medication Records Are Up-to-Date After Hospital Discharge
Label for Data:	The Plan Makes Sure Member Medication Records Are Up-to-Date After Hospital Discharge
Description:	This shows the percent of plan members whose medication records were updated within 30 days after leaving the hospital. To update the record, a doctor or other health care professional looks at the new medications prescribed in the hospital and compares them with the other medications the patient takes. Updating medication records can help to prevent errors that can occur when medications are changed.
HEDIS Label:	Medication Reconciliation Post-Discharge (MRP)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 330
Metric:	The percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Seamless Care Coordination

Title	Description

CMIT #: 00441-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 38%	38% to less than 52%	52% to less than 68%	68% to less than 82%	greater than or equal to 82%

Measure: C15 - Plan All-Cause Readmissions

Title	Description

Label for Stars: Readmission to a Hospital within 30 Days of Being Discharged (more stars are better because it means fewer members are being readmitted)

Label for Data: Readmission to a Hospital within 30 Days of Being Discharged (lower percentages are better because it means fewer members are being readmitted)

Description: Percent of plan members aged 18 and older discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.
(Patients may have been readmitted back to the same hospital or to a different one. Rates of readmission take into account how sick patients were when they went into the hospital the first time. This "risk-adjustment" helps make the comparisons between plans fair and meaningful.)

HEDIS Label: Plan All-Cause Readmissions (PCR)

Measure Reference: NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 498

Metric: The percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for members 18 years of age and older using the following formula to control for differences in the case mix of patients across different contracts.

For contract A, their case-mix adjusted readmission rate relative to the national average is the observed readmission rate for contract A divided by the expected readmission rate for contract A. This ratio is then multiplied by the national average observed rate.

See Attachment F: Calculating MeasureC15: Plan All-Cause Readmissions (18+) for the complete formula, example calculation and National Average Observation value used to complete this measure.

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Exclusions: Exclude hospital stays for the following reasons:

- The member died during the stay.
- Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.

Title	Description
	• A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2021 enrollment report are excluded from this measure. As listed in the HEDIS Technical Specifications. CMS has excluded contracts whose denominator was less than 150.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Included
Case-Mix Adjusted:	Yes
Weighting Category:	Outcome Measure
Weighting Value:	1
Major Disaster:	New Measure Hold Harmless Provision.
Meaningful Measure Area:	Admissions and Readmissions to Hospitals
CMIT #:	00561-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
greater than 13%	greater than 11% to less than or equal to 13%	greater than 10% to less than or equal to 11%	greater than 8% to less than or equal to 10%	less than or equal to 8%

Measure: C16 - Statin Therapy for Patients with Cardiovascular Disease

Title	Description
Label for Stars:	The Plan Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol
Label for Data:	The Plan Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol
Description:	This rating is based on the percent of plan members with heart disease who get the right type of cholesterol-lowering drugs. Health plans can help make sure their members are prescribed medications that are more effective for them.
HEDIS Label:	Statin Therapy for Patients with Cardiovascular Disease (SPC)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 168
Metric:	The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) (denominator) and were dispensed at least one high or moderate-intensity statin medication during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude members who meet any of the following criteria: • Pregnancy (Pregnancy Value Set) during the measurement year or year prior to the measurement year. • In vitro fertilization (IVF Value Set) in the measurement year or year prior to the measurement year. • Dispensed at least one prescription for clomiphene (Table SPC-A) during the measurement year or the year prior to the measurement year. • ESRD (ESRD Value Set) during the measurement year or the year prior to the measurement year. • Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. • Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year with frailty (Frailty Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria:

Title	Description

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
- A dispensed dementia medication (Dementia Medications List).

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2022 – 12/31/2022

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00700-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 79%	79% to less than 84%	84% to less than 86%	86% to less than 90%	greater than or equal to 90%

Measure: C17 - Transitions of Care

Title	Description
Label for Stars:	After hospital stay, members receive information and care they need
Label for Data:	After hospital stay, members receive information and care they need
Description:	This rating is based on the percent of plan members who got follow-up care after a hospital stay. Follow-up care includes: getting information about their health problem and what to do next, having a visit or call with a doctor, and having a doctor or pharmacist make sure the plan member's medication records are up to date.
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 330
Metric:	The average of the rates for Transitions of Care - Medication Reconciliation Post-Discharge, Transitions of Care - Notification of Inpatient Admission, Transitions of Care - Patient Engagement After Inpatient Discharge, and Transitions of Care - Receipt of Discharge Information.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Members that do not have continuous enrollment from the date of discharge through 30 days after discharge (31 total days) are excluded. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	New Measure Hold Harmless Provision.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00729-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 40%	40% to less than 52%	52% to less than 64%	64% to less than 78%	greater than or equal to 78%

Measure: C18 - Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Title	Description
Label for Stars:	Members with 2 or more chronic conditions receive follow-up care within 7 days after an emergency department visit
Label for Data:	Members with 2 or more chronic conditions receive follow-up care within 7 days after an emergency department visit
Description:	This rating is based on the percent of plan members with 2 or more chronic conditions who got follow-up care within 7 days after they had an emergency department (ED) visit. Depending on the person's needs this might be a visit with a health care provider, an appointment with a case manager, or a home visit.
HEDIS Label:	Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 340
Metric:	The percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.
Primary Data Source:	HEDIS

Title	Description
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. These events are excluded from the measure because admission to an acute or nonacute setting may prevent an outpatient follow-up visit from taking place Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	New Measure Hold Harmless Provision.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00263-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 44%	44% to less than 53%	53% to less than 60%	60% to less than 68%	greater than or equal to 68%

Domain: 3 - Member Experience with Health Plan

Measure: C19 - Getting Needed Care

Title	Description
Label for Stars:	Ease of Getting Needed Care and Seeing Specialists
Label for Data:	Ease of Getting Needed Care and Seeing Specialists (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get needed care, including care from specialists.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for a member to get needed care and see specialists. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? • In the last 6 months, how often was it easy to get the care, tests or treatment you needed?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Title	Description
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00293-02-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 76	76 to less than 78	78 to less than 81	81 to less than 83	greater than or equal to 83

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C20 - Getting Appointments and Care Quickly

Title	Description
Label for Stars:	Getting Appointments & Care Quickly
Label for Data:	Getting Appointments & Care Quickly (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how quickly members get appointments and care.
Metric:	This case-mix adjusted composite measure is used to assess how quickly the member was able to get appointments and care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? • In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
General Trend:	Higher is better

Title	Description
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00292-01-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 74	74 to less than 76	76 to less than 78	78 to less than 80	greater than or equal to 80

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C21 - Customer Service

Title	Description
Label for Stars:	Health Plan Provides Information or Help When Members Need It
Label for Data:	Health Plan Provides Information or Help When Members Need It (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for the member to get information and help when needed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS

Data Source Description:

- CAHPS Survey Questions (question numbers vary depending on survey type):

Title	Description
	• In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms from your health plan easy to fill out?

Data Source Category: Survey of Enrollees

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2023 – 06/2023

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 4

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00181-01-C-PARTC

Data Display: Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 88	88 to less than 89	89 to less than 90	90 to less than 92	greater than or equal to 92

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C22 - Rating of Health Care Quality

Title	Description
Label for Stars:	Members' Rating of Health Care Quality
Label for Data:	Members' Rating of Health Care Quality (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned from members who rated the quality of the health care they received.
Metric:	This case-mix adjusted measure is used to assess members' view of the quality of care received from the health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00642-01-C-PARTC
Data Display:	Numeric with no decimal place

Title	Description

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 84	84 to less than 85	85 to less than 87	87 to less than 88	greater than or equal to 88

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C23 - Rating of Health Plan

Title	Description

Label for Stars: Members' Rating of Health Plan

Label for Data: Members' Rating of Health Plan (on a scale from 0 to 100)

Description: Percent of the best possible score the plan earned from members who rated the health plan.

Metric: This case-mix adjusted measure is used to assess members' overall view of their health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Primary Data Source: CAHPS

Data Source Description: CAHPS Survey Question (question numbers vary depending on survey type):

- Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

Data Source Category: Survey of Enrollees

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2023 – 06/2023

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Patients' Experience and Complaints Measure

Title	Description
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
	Person-Centered Care
CMIT #:	00643-02-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 84	84 to less than 85	85 to less than 88	88 to less than 89	greater than or equal to 89

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C24 - Care Coordination

Title	Description
Label for Stars:	Coordination of Members' Health Care Services
Label for Data:	Coordination of Members' Health Care Services (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how well the plan coordinates members' care. (This includes whether doctors had the records and information they needed about members' care and how quickly members got their test results.)
Metric:	This case-mix adjusted composite measure is used to assess Care Coordination. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale of 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type):

- In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?

Title	Description
	• In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

Data Source Category: Survey of Enrollees

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2023 – 06/2023

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 4

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Seamless Care Coordination

CMIT #: 00106-02-C-PARTC

Data Display: Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 83	83 to less than 84	84 to less than 86	86 to less than 87	greater than or equal to 87

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SCAN HEALTH PLAN, *Plaintiff*, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	Case No. 1:23-cv-3910-CJN

JOINT APPENDIX

VOLUME V

Tabs 25 (Pt. 2) – 27

Adjudication Record ("A.R.")

Tab	Document Description	A.R. Page Range
25 (Pt. 2)	Reconsideration Official's Decision	SCAN-AR00586 – 00723
26	SCAN's Reconsideration Request	SCAN-AR00999 – 01003
27	Emails from Call Center Monitoring Contractor	SCAN-AR01034 – 01047

TAB 25
(Part 2)

Domain: 4 - Member Complaints and Changes in the Health Plan's Performance

Measure: C25 - Complaints about the Health Plan

Title	Description
Label for Stars:	Complaints about the Health Plan (more stars are better because it means fewer complaints)
Label for Data:	Complaints about the Health Plan (lower numbers are better because it means fewer complaints)
Description:	Rate of complaints filed with Medicare about the health plan.
Metric:	Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the Complaints Tracking Module (CTM)) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period). Number of Days in Period = 366 for leap years, 365 for all other years. • Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data. • Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract. • A contract's failure to follow CMS's CTM Standard Operating Procedures will not result in CMS's adjustment of the data used for these measures.
Primary Data Source:	Complaints Tracking Module (CTM)
Data Source Description:	Data were obtained from the CTM in the Health Plan Management System (HPMS) based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. The status of any specific complaint at the time the data are pulled stands for use in the reports. Any changes to the complaints data subsequent to the data pull cannot be excluded retroactively. CMS allows for an approximate 6-month "wash out" period to account for any adjustments per CMS's CTM Standard Operating Procedures. Therefore, all Plan Requests for 2022 complaints made by June 30, 2023 are captured. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis. Monthly enrollment files from HPMS were used to calculate the average enrollment for the contract for the measurement period.
Data Source Category:	CMS Administrative Data
Exclusions:	On May 10, 2019, CMS released an HPMS memo on the Complaints Tracking Module (CTM) Updated Standard Operating Procedures (SOP). Plans should review all complaints at intake and verify the contract assignment and issue level. The APPENDIX A - Category and Subcategory Listing in the SOP lists the subcategories that are excluded. Complaint rates are not calculated for contracts with average enrollment of less than 800 enrollees during the measurement period.
Data Time Frame:	01/01/2022 – 12/31/2022

Title	Description
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00142-02-C-PARTC
Data Display:	Numeric with 2 decimal places

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 0.75	less than 0.5 to 0.75	less than 0.32 to 0.5	less than 0.14 to 0.32	less than or equal to 0.14

Measure: C26 - Members Choosing to Leave the Plan

Title	Description
Label for Stars:	Members Choosing to Leave the Plan (more stars are better because it means fewer members choose to leave the plan)
Label for Data:	Members Choosing to Leave the Plan (lower percentages are better because that indicates fewer members choose to leave the plan)
Description:	Percent of plan members who chose to leave the plan.
Metric:	The percent of members who chose to leave the contract comes from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the contract between January 1, 2022–December 31, 2022 (numerator) divided by all members enrolled in the contract at any time during 2022 (denominator).
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)

Title	Description
Data Source Category:	CMS Administrative Data
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • Contracts with less than 1,000 enrollees • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2022 and 12/31/2022 who disenrolled from the contract with any one of the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan 13 - Disenrollment because of enrollment in another Plan 14 - Retroactive 99 - Other (not supplied by beneficiary). If all potential members in the numerator meet one or more of the exclusion criteria, the measure result will be "Not enough data available". The Disenrollment Reasons Survey (DRS) data available in the HPMS plan preview and in the CMS downloadable Master Table, are not used in the calculation of this measure. The DRS data are presented in each of the systems for information purposes only.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included

Title	Description
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00446-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 41%	less than 29% to 41%	less than 18% to 29%	less than 10% to 18%	less than or equal to 10%

Measure: C27 - Health Plan Quality Improvement

Title	Description
Label for Stars:	Improvement (if any) in the Health Plan's Performance
Label for Data:	Improvement (if any) in the Health Plan's Performance
Description:	This shows how much the health plan's performance improved or declined from one year to the next. If a plan receives **1 or 2 stars**, it means, on average, the plan's scores **declined** (got worse). If a plan receives **3 stars**, it means, on average, the plan's scores **stayed about the same**. If a plan receives **4 or 5 stars**, it means, on average, the plan's scores **improved**. Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.
Metric:	The numerator is the net improvement, which is a weighted sum of the number of significantly improved measures minus the number of significantly declined measures. The denominator is the sum of the weights associated with the measures eligible for the improvement measure (i.e., the measures that were included in the 2022 and 2023 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2022 and 2023 Star Ratings

Title	Description
Data Source Category:	Star Ratings
Exclusions:	Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.
General Notes:	Attachment H contains the formulas used to calculate the improvement measure and lists indicating which measures were used.
Data Time Frame:	Not Applicable
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Improvement Measure
Weighting Value:	5
Major Disaster:	Includes only measures which have data from both years.
Meaningful Measure Area:	Person-centered Care
CMIT #:	00300-01-C-PARTC
Data Display:	Not Applicable

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than -0.246067	-0.246067 to less than 0	0 to less than 0.173502	0.173502 to less than 0.393451	greater than or equal to 0.393451

Domain: 5 - Health Plan Customer Service

Measure: C28 - Plan Makes Timely Decisions about Appeals

Title	Description
Label for Stars:	Health Plan Makes Timely Decisions about Appeals
Label for Data:	Health Plan Makes Timely Decisions about Appeals
Description:	This rating shows how fast a plan sends information for an independent review.
Metric:	Percent of appeals timely processed by the plan (numerator) out of all the plan's appeals decided by the Independent Review Entity (IRE) (includes upheld, overturned, partially overturned appeals and dismissed because the plan agreed to cover) (denominator). This is calculated as: ([Number of Timely Appeals] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned] + [Appeals Dismissed Because Plan Agreed to Cover])) * 100
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. The timeliness is based on the actual IRE received date and is compared to the date the appeal should have been received by the IRE.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	If the denominator is ≤ 10, the result is "Not enough data available." Dismissed for reasons other than the plan agreed to cover and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers. The number of timely appeals can be calculated using this formula: [Number of Timely Appeals] = ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]) + [Appeals Dismissed Because Plan Agreed to Cover]) - [Late] Note: When reviewing IRE data from the Maximus appeals website found at http://www.medicareappeal.com/AppealSearch and in data files, appeal disposition codes have been updated from the prior codes. Below is a crosswalk of previous appeal disposition codes and current codes:

Previous Field Name	Current Field Name
Upheld	Unfavorable
Overturn	Favorable
Partially Overturn	Partially favorable

Title	Description
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Affordability and Efficiency
CMIT #:	00562-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 84%	84% to less than 88%	88% to less than 94%	94% to less than 98%	greater than or equal to 98%

Measure: C29 - Reviewing Appeals Decisions

Title	Description
Label for Stars:	Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer
Label for Data:	Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer
Description:	This rating shows how often an independent reviewer found the health plan's decision to deny coverage to be reasonable.
Metric:	Percent of appeals where a plan's decision was "upheld" by the Independent Review Entity (IRE) (numerator) out of all the plan's appeals (upheld, overturned, and partially overturned appeals only) that the IRE reviewed (denominator). This is calculated as:

Title	Description
	([Appeals Upheld] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]))* 100.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. If a Reopening occurs and is decided prior to June 30, 2023, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after June 30, 2023 are not reflected in these data the original decision result is used. The results of appeals that occur beyond Level 2 (i.e., Administrative Law Judge or Medicare Appeals Council appeals) are not included in the data.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	If the minimum number of appeals (upheld + overturned + partially overturned) is ≤ 10, the result is "Not enough data available." Dismissed and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Affordability and Efficiency
CMIT #:	00652-01-C-PARTC
Data Display:	Percentage with no decimal place

Title	Description

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 87%	87% to less than 92%	92% to less than 96%	96% to less than 100%	equal to 100%

Measure: C30 - Call Center – Foreign Language Interpreter and TTY Availability

Title	Description
Label for Stars:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Health Plan
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Health Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by people who called the health plan's prospective enrollee customer service phone line.
Metric:	The calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within eight minutes. Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within seven minutes.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, organizations that did not have a phone number accessible to survey callers, and MAOs, MA-PDs, and MMPs under sanction.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/2023 – 05/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included

Title	Description
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	4
Major Disaster:	No adjustment for 2021 or 2022 disasters.
Meaningful Measure Area:	Person-centered Care
CMIT #:	00096-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	Yes	No	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 72%	72% to less than 83%	83% to less than 92%	92% to less than 97%	greater than or equal to 97%

Part D Domain and Measure Details

See Attachment C for the national averages of individual Part D measures.

Domain: 1 - Drug Plan Customer Service

Measure: D01 - Call Center – Foreign Language Interpreter and TTY Availability

Title	Description
Label for Stars:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by people who called the drug plan's prospective enrollee customer service line.
Metric:	The calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the plan's Medicare Part D benefit within eight minutes. Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the plan's Medicare Part D benefit within seven minutes.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, organizations that did not have a phone number accessible to survey callers, and MA-PDs, PDPs, and MMPs under sanction.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/2023 – 05/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access

Title	Description

Weighting Value: 4

Major Disaster: No adjustment for 2021 or 2022 disasters.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00096-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 73%	73% to less than 86%	86% to less than 96%	96% to less than 99%	greater than or equal to 99%
PDP	less than 91%	91% to less than 97%	97% to less than 98%	98% to less than 100%	equal to 100%

Domain: 2 - Member Complaints and Changes in the Drug Plan's Performance

Measure: D02 - Complaints about the Drug Plan

Title	Description
Label for Stars:	Complaints about the Drug Plan (more stars are better because it means fewer complaints)
Label for Data:	Complaints about the Drug Plan (number of complaints for every 1,000 members). (Lower numbers are better because it means fewer complaints.)
Description:	Rate of complaints filed with Medicare about the drug plan.
Metric:	Rate of complaints about the drug plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the Complaints Tracking Module (CTM)) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period). Number of Days in Period = 366 for leap years, 365 for all other years. • Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data. • Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract. • A contract's failure to follow CMS's CTM Standard Operating Procedures will not result in CMS's adjustment of the data used for these measures.
Primary Data Source:	Complaints Tracking Module (CTM)
Data Source Description:	Data were obtained from the CTM in the Health Plan Management System (HPMS) based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. The status of any specific complaint at the time the data are pulled stands for use in the reports. Any changes to the complaints data subsequent to the data pull cannot be excluded retroactively. CMS allows for an approximate 6-month "wash out" period to account for any adjustments per CMS's CTM Standard Operating Procedures. Therefore, all Plan Requests for 2022 complaints made by June 30, 2023 are captured Complaint rates per 1,000 enrollees are adjusted to a 30-day basis. Monthly enrollment files from HPMS were used to calculate the average enrollment for the contract for the measurement period.
Data Source Category:	CMS Administrative Data
Exclusions:	On May 10, 2019, CMS released an HPMS memo on the Complaints Tracking Module (CTM) Updated Standard Operating Procedures (SOP). Plans should review all complaints at intake and verify the contract assignment and issue level. The APPENDIX A - Category and Subcategory Listing in the SOP lists the subcategories that are excluded. Complaint rates are not calculated for contracts with average enrollment of less than 800 enrollees during the measurement period.
Data Time Frame:	01/01/2022 – 12/31/2022

Title	Description
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00142-02-C-PARTD
Data Display:	Numeric with 2 decimal places

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 0.75	greater than0.5 to 0.75	greater than 0.32 to 0.5	greater than 0.14 to 0.32	less than or equal to 0.14
PDP	greater than 0.14	greater than0.09 to 0.14	greater than 0.06 to 0.09	greater than 0.02 to 0.06	less than or equal to 0.02

Measure: D03 - Members Choosing to Leave the Plan

Title	Description
Label for Stars:	Members Choosing to Leave the Plan (more stars are better because it means fewer members choose to leave the plan)
Label for Data:	Members Choosing to Leave the Plan (lower percentages are better because that indicates fewer members choose to leave the plan)
Description:	Percent of plan members who chose to leave the plan.
Metric:	The percent of members who chose to leave the contract comes from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the contract between January 1, 2022–December 31, 2022 (numerator) divided by all members enrolled in the contract at any time during 2022 (denominator).

Title	Description
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)
Data Source Category:	CMS Administrative Data
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • Contracts with less than 1,000 enrollees • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2022 and 12/31/2022 who disenrolled from the contract with any one of the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan 13 - Disenrollment because of enrollment in another Plan 14 - Retroactive 99 - Other (not supplied by beneficiary). If all potential members in the numerator meet one or more of the exclusion criteria, the measure result will be "Not enough data available". The Disenrollment Reasons Survey (DRS) data available in the HPMS plan preview and in the CMS downloadable Master Table, are not used in the calculation of this measure. The DRS data are presented in each of the systems for information purposes only.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Lower is better
Statistical Method:	Clustering

Title	Description
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00446-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	greater than 41%	greater than 29% to 41%	greater than 18% to 29%	greater than10% to 18%	less than or equal to 10%
PDP	greater than 23%	greater than 17% to 23%	greater than 11% to 17%	greater than 7% to 11%	less than or equal to 7%

Measure: D04 - Drug Plan Quality Improvement

Title	Description
Label for Stars:	Improvement (if any) in the Drug Plan's Performance
Label for Data:	Improvement (If any) in the Drug Plan's Performance
Description:	This shows how much the drug plan's performance has improved or declined from one year to the next year. If a plan receives **1 or 2 stars**, it means, on average, the plan's scores **declined** (got worse). If a plan receives **3 stars**, it means, on average, the plan's scores **stayed about the same**. If a plan receives **4 or 5 stars**, it means, on average, the plan's scores **improved**. Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.
Metric:	The numerator is the net improvement, which is a weighted sum of the number of significantly improved measures minus the number of significantly declined measures.

Title	Description
	The denominator is the sum of the weights associated with the measures eligible for the improvement measure (i.e., the measures that were included in the 2023 and 2024 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2023 and 2024 Star Ratings
Data Source Category:	Star Ratings
Exclusions:	Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.
General Notes:	Attachment I contains the formulas used to calculate the improvement measure and lists indicating which measures were used.
Data Time Frame:	Not Applicable
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Improvement Measure
Weighting Value:	5
Major Disaster:	Includes only measures which have data from both years.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00224-01-C-PARTD
Data Display:	Not Applicable

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than -0.253472	-0.253472 to less than 0	0 to less than 0.193739	0.193739 to less than 0.458889	greater or equal to 0.458889
PDP	less than -0.123026	-0.123026 to less than 0	0 to less than 0.214538	0.214538 to less than 0.401223	greater than or equal to 0.401223

Domain: 3 - Member Experience with the Drug Plan

Measure: D05 - Rating of Drug Plan

Title	Description
Label for Stars:	Members' Rating of Drug Plan
Label for Data:	Members' Rating of Drug Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned from members who rated the prescription drug plan.
Metric:	This case-mix adjusted measure is used to assess members' overall view of their prescription drug plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care

Title	Description
CMIT #:	00641-01-C-PARTD
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	No	Yes	Yes

Base Group Cut Points:

Type	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
MA-PD	less than 84	84 to less than 85	85 to less than 87	87 to less than 89	greater than or equal to 89
PDP	less than 80	80 to less than 81	81 to less than 83	83 to less than 87	greater than or equal to 87

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: D06 - Getting Needed Prescription Drugs

Title	Description
Label for Stars:	Ease of Getting Prescriptions Filled When Using the Plan
Label for Data:	Ease of Getting Prescriptions Filled When Using the Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get the prescription drugs they need using the plan.
Metric:	This case-mix adjusted measure is used to assess the ease with which a beneficiary gets the medicines their doctor prescribed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed? • In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy? • In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
General Trend:	Higher is better

Title	Description

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 4

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00294-01-C-PARTD

Data Display: Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	No	Yes	Yes

Base Group Cut Points:

Type	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
MA-PD	less than 87	87 to less than 89	89 to less than90	90 to less than 91	greater than or equal to 91
PDP	less than 87	87 to less than88	88 to less than 90	90 to less than 91	greater than or equal to 91

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Domain: 4 - Drug Safety and Accuracy of Drug Pricing

Measure: D07 - MPF Price Accuracy

Title	Description
Label for Stars:	Plan Provides Accurate Drug Pricing Information for This Website
Label for Data:	Plan Provides Accurate Drug Pricing Information for This Website (higher scores are better because they mean more accurate prices)
Description:	A score comparing the drug's total cost at the pharmacy to the drug prices the plan provided for the Medicare Plan Finder website. Higher scores are better because they mean the plan provided more accurate prices.
Metri	This measure evaluates the accuracy of drug prices posted on the MPF tool. A contract's score is based on the accuracy index, or magnitude of difference, and the claim percentage index, or frequency of difference. The accuracy index – or magnitude of difference - considers both ingredient cost and dispensing fee and measures the amount that the PDE price is higher than the MPF price. The claim percentage index – or frequency of difference - also considers both ingredient cost and dispensing fee while measuring how often the PDE price is higher than the MPF price. Therefore, prices that are overstated on MPF will not count against a plan's score. The accuracy index is computed as: (Total amount that PDE is higher than MPF + Total PDE cost) / (Total PDE cost). The claim percentage index is computed as: (Total number of PDEs where PDE cost is higher than MPF) / (Total number of PDEs). The best possible accuracy index is 1 and claim percentage index is 0. Indexes with these values indicate that a plan did not have PDE prices greater than MPF prices. A contract's score is computed using its accuracy index and claim percentage index as: .5 x (100 – ((accuracy index – 1) x 100)) + .5 x ((1 – claim percentage index) x 100).
Primary Data Source:	PDE data, MPF Pricing Files
Data Source Description:	Data used in this measure are obtained from a number of sources: MPF Pricing Files and PDE data are the primary data sources. The PDE data were submitted by drug plans to CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022- September 30, 2022. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the measure. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2022 PDE submission deadline are used to calculate this measure. The HPMS-approved formulary extracts, and data from First DataBank and Medi-span are also used.

Title	Description
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	A contract with less than 30 PDE claims over the measurement period. PDEs must also meet the following criteria: • If the NPI in the Pharmacy Cost (PC) file represents a retail only pharmacy or retail and limited access drug only pharmacy, all corresponding PDEs will be eligible for the measure. However, if the NPI in the PC file represents a retail and other pharmacy type (such as Mail, Home Infusion or Long Term Care pharmacy), only the PDE where the pharmacy service type is identified as either Community/Retail or Managed Care Organization (MCO) will be eligible. • Drug must appear in formulary file and in MPF pricing file • PDE must be a 28-34, 60-62, or 90-93 day supply. If a plan's bid indicates a 1, 2, or 3 month retail days supply amount outside of the 28-34, 60-62, or 90-93 windows, then additional days supply values may be included in the accuracy measure for the plan. • Date of service must occur at a time that data are not suppressed for the plan on MPF • PDE must not be a compound claim • PDE must not be a non-covered drug
General Notes:	Please see Attachment M: Methodology for Price Accuracy Measure for more information about this measure.
Data Time Frame:	01/01/2022 – 09/30/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Affordability and Efficiency
CMIT #:	00452-01-C-PARTD

Title	Description
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 94	94 to less than 96	96 to less than 98	98 to less than 99	greater than or equal to 99
PDP	less than 96	96 to less than 97	97 to less than 98	98 to less than 99	greater than or equal to 99

Measure: D08 - Medication Adherence for Diabetes Medications

Title	Description
Label for Stars:	Taking Diabetes Medication as Directed
Label for Data:	Taking Diabetes Medication as Directed

Description: Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

One of the most important ways people with diabetes can manage their health is by taking their medication as directed. The plan, the doctor, and the member can work together to find ways to do this. ("Diabetes medication" means a *biguanide drug*, a *sulfonylurea drug*, a *thiazolidinedione drug*, a *DPP-4 inhibitor*, a *GLP-1 receptor agonist*, a *meglitinide drug*, or an *SGLT2 inhibitor*. Plan members who take insulin are not included.)

Metric: This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, DiPeptidyl Peptidase (DPP)-4 Inhibitors, GLP-1 receptor agonists, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two fills of diabetes medication(s) on unique dates of service during the measurement period (denominator).

The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their diabetes medication occurs at least 91 days before the end of the enrollment period.

The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA).

See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.

Title	Description
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022-December 31, 2022. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2022 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for diabetes medication(s). PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Encounter Data Systems (EDS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient (IP) and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for insulin
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode.

Title	Description

The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12).

The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by the active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment for IP/SNF stays. Please see Attachment L: Medication Adherence Measure Calculations for more information about these calculation adjustments.

When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.

Data Time Frame: 01/01/2022 – 12/31/2022

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00436-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 80%	80% to less than 84%	84% to less than 88%	88% to less than 90%	greater than or equal to 90%
PDP	less than 84%	84% to less than 87%	87% to less than 89%	89% to less than93%	greater than or equal to 93%

Measure: D09 - Medication Adherence for Hypertension (RAS antagonists)

Title	Description
Label for Stars:	Taking Blood Pressure Medication as Directed
Label for Data:	Taking Blood Pressure Medication as Directed
Description:	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. One of the most important ways people with high blood pressure can manage their health is by taking medication as directed. The plan, the doctor, and the member can work together to do this. ("Blood pressure medication" means an *ACEI (angiotensin converting enzyme inhibitor)*, an *ARB (angiotensin receptor blocker)*, or a *direct renin inhibitor drug*.)
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for RAS antagonist medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two RAS antagonist medication fills on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their RAS antagonist medication occurs at least 91 days before the end of the enrollment period. The Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). See the medication list for this measure. The Part D Medication Adherence rate is calculated using the National Drug Code (NDC) list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022-December 31, 2022. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2022 PDE submission deadline are used to calculate this measure. PDE claims are limited to

Title	Description
	members who received at least two prescriptions on unique dates of service for RAS antagonist medication(s). PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), and the Common Working File (CWF), and the Encounter Data Systems (EDS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for sacubitril/valsartan
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment L: Medication Adherence Measure Calculations for more information about these calculation adjustments.

Title	Description
	When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00437-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 82%	82% to less than 86%	86% to less than 89%	89% to less than 91%	greater than or equal to 91%
PDP	less than 87%	87% to less than 89%	89% to less than 91%	91% to less than 94%	greater than or equal to 94%

Measure: D10 - Medication Adherence for Cholesterol (Statins)

Title	Description
Label for Stars:	Taking Cholesterol Medication as Directed
Label for Data:	Taking Cholesterol Medication as Directed
Description:	Percent of plan members with a prescription for a cholesterol medication (a *statin drug*) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. One of the most important ways people with high cholesterol can manage their health is by taking medication as directed. The plan, the doctor, and the member can work together to do this.
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for statin cholesterol medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for statin cholesterol medication(s) during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two statin cholesterol medication fills on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in the therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their statin medication occurs at least 91 days before the end of the enrollment period. The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022-December 31, 2022. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2022 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for statin medication. PDE adjustments made post-reconciliation were not reflected in this measure.

Title	Description
	Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Encounter Data Systems (EDS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient (IP) and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment L: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2022 – 12/31/2022

Title	Description
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00435-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 82%	82% to less than 86%	86% to less than 88%	88% to less than 91%	greater than or equal to 91%
PDP	less than 84%	84% to less than 87%	87% to less than 89%	89% to less than 93%	greater than or equal to 93%

Measure: D11 - MTM Program Completion Rate for CMR

Title	Description
Label for Stars:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Label for Data:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Description:	Some plan members are in a program (called a *Medication Therapy Management* program) to help them manage their drugs. The measure shows how many members in the program had an assessment of their medications from the plan. The assessment includes a discussion between the member and a pharmacist (or other health care professional) about all of the member's medications. The member also receives a written summary of the discussion, including an action plan that recommends what the member can do to better understand and use his or her medications.

Title	Description
Metric:	This measure is defined as the percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period. Numerator = Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period. Denominator = Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period. Only those beneficiaries who meet the contracts' specified targeting criteria per CMS – Part D requirements pursuant to §423.153(d) of the regulations at any time in the reporting period are included in this measure. Beneficiaries who were in hospice at any point during the reporting period are excluded. Beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time in the measurement year are included in the denominator and the numerator if they received a CMR within this timeframe. Beneficiaries are excluded from the measure calculation if they were enrolled in the contract's MTM program for less than 60 days and did not receive a CMR within this timeframe. The date of enrollment is counted towards the 60 days but the opt-out date is not. A beneficiary's MTM eligibility, receipt of CMRs, etc., is determined for each contract he/she was enrolled in during the measurement period. Similarly, a contract's CMR completion rate is calculated based on each of its eligible MTM enrolled beneficiaries. For example, a beneficiary must meet the inclusion criteria for the contract to be included in the contract's CMR rate. A beneficiary who is enrolled in two different contracts' MTM programs for 30 days each is therefore excluded from both contracts' CMR rates. The beneficiary is only included in the measure calculation for the contract(s) where they were enrolled at least 60 days. Beneficiaries with multiple records that contain varying information for the same contract are excluded from the measure calculation for that contract. Beneficiaries may be enrolled in MTM based on the contracts' specified targeting criteria per CMS – Part D requirements and/or based on expanded, other plan-specific targeting criteria. Beneficiaries who were initially enrolled in MTM due to other plan-specific (expanded) criteria and then later met the contracts' specified targeting criteria per CMS – Part D requirements at any time in the reporting period are included in this measure. In these cases, a CMR received after the date of MTM enrollment but before the date the beneficiary met the specified targeting criteria per CMS – Part D requirements are included.
Primary Data Source:	Part D Plan Reporting
Data Source Description:	The data for this measure were reported by contracts to CMS per the 2022 Part D Reporting Requirements (data pulled June 2023). Validation of these data was performed retrospectively during the 2023 data validation cycle (deadline June 30, 2023 and data validation results pulled July 2023). Additionally, the Medicare Enrollment Database (EDB) is used for hospice enrollment (data pulled March 2023).
Data Source Category:	Health and Drug Plans

Title	Description
Exclusions:	Contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2023) are excluded and listed as "No data available." MTM CMR rates are not provided for contracts that did not score at least 95% on data validation for the Medication Therapy Management Program reporting section or were not compliant with data validation standards/sub-standards for any of the following Medication Therapy Management Program data elements. We define a contract as being non-complaint if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation. • MBI Number (Element B) • Date of MTM program enrollment (Element H) • Met the specified targeting criteria per CMS – Part D requirements (Element F) • Date met the specified targeting criteria per CMS – Part D requirements (Element J) • Date of MTM program opt-out, if applicable (Element K) • Received annual CMR with written summary in CMS standardized format (Element O) • Date(s) of CMR(s) (Element P) MTM CMR rates are also not provided for contracts that failed to submit their MTM file and pass system validation by the reporting deadline or who had a missing data validation score for MTM. Contracts excluded from the MTM CMR Rates due to data validation issues are shown as "CMS identified issues with this plan's data." See Attachment N for more details on the MTM CMR completion rate measure scoring methodology. Contracts can view their data validation results in HPMS (https://hpms.cms.gov/). To access this page, from the top menu select "Monitoring," then "Plan Reporting Data Validation." Select the appropriate contract year. Select the PRDVM Reports. Select "Score Detail Report." Select the applicable reporting section. If you cannot see the Plan Reporting Data Validation module, contact CMS at HPMS_Access@cms.hhs.gov. Additionally, contracts must have 31 or more enrollees in the denominator in order to have a calculated rate. Contracts with fewer than 31 eligible enrollees are listed as "Not enough data available".
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included

Title	Description
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00454-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 67%	67% to less than 77%	77% to less than 85%	85% to less than 92%	greater than or equal to 92%
PDP	less than 34%	34% to less than 52%	52% to less than 63%	63% to less than 77%	greater than or equal to 77%

Measure: D12 - Statin Use in Persons with Diabetes (SUPD)

Title	Description
Label for Stars:	The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol
Label for Data:	The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol
Description:	To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of plan members with diabetes who take the most effective cholesterol-lowering drugs. Plans can help make sure their members get these prescriptions filled.
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills on unique dates of service and received a statin medication fill during the measurement period. The percentage is calculated as the number of member-years of enrolled beneficiaries 40-75 years old who received a statin medication fill during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 40-75 years old with at least two diabetes medication fills on unique dates of service during the measurement period (denominator). Beneficiaries are only included in the measure calculation if the first fill of their diabetes medication occurs at least 90 days before the end of the measurement year or end of the enrollment episode.

Title	Description
	The SUPD measure is adapted from the measure concept that was developed and endorsed by the Pharmacy Quality Alliance (PQA). See the medication list for this measure. The SUPD measure is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists, including diagnosis codes, are posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from Prescription Drug Event (PDE) data submitted by drug plans to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022 – December 31, 2022. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2022 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Encounter Data Systems (EDS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes. • EDS is used to identify diagnoses based on ICD-10-CM codes.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates • Rhabdomyolysis and myopathy • Pregnancy • Lactation and fertility • Cirrhosis • Pre-Diabetes • Polycystic Ovary Syndrome

Title	Description
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member years for each episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12).
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00702-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 81%	81% to less than 86%	86% to less than 88%	88% to less than 92%	greater than or equal to 92%
PDP	less than 81%	81% to less than 83%	83% to less than 85%	85% to less than 87%	greater than or equal to 87%

Attachment A: CAHPS Case-Mix Adjustment

CAHPS Case-Mix Adjustment

The CAHPS measures are case-mix adjusted to take into account the mix of enrollees. Case-mix variables include administrative age, dual eligibility status, low-income subsidy (LIS) indicator, and use of Asian language survey, and self-reported education, general health status, mental health status, and proxy usage status. The tables below include the case-mix variables and show the case-mix coefficients for each of the CAHPS measures included in the Star Ratings. The coefficients indicate how much higher or lower people with a given characteristic tend to respond compared to otherwise similar people with the baseline value for that characteristic (e.g., reference group), on the original scale of the item or composite, as presented in plan reports. The reference group for each characteristic will have a coefficient value of zero.

For example, for the measure "Rating of Health Care Quality," the model coefficient for "age 75-79" is 0.0521, indicating that respondents in that age range tend to score their plans 0.0521 points higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, Medicaid dual eligibles tend to respond 0.0322 points lower on this item than otherwise similar non-duals. Contracts with higher proportions of beneficiaries who are in the 75-79 age range will be adjusted downward on this measure to compensate for the positive response tendency of their respondents. Similarly, contracts with higher proportions of respondents who are Medicaid dual eligibles will be adjusted upward on this measure to compensate for their respondents' negative response tendency. The case-mix patterns are not always consistent across measures. Missing case-mix adjustors are imputed as the contract mean.

The composites consist of multiple items, each of which is adjusted separately before combining the adjusted scores into a composite score. Item-level coefficients are presented below separately for each composite. For more detailed information on the application of CAHPS case-mix adjustment, please review the materials at https://ma-pdpcahps.org/en/scoring-and-star-ratings/.

Table A-1: Coefficients of Part C Getting Needed Care (C19) CAHPS Measure Composite Items

Predictor	Get Appointment with Specialist	Easy to Get Care
Age: 64 or under	0.0414	-0.0138
Age: 65 – 69	0.0069	-0.0144
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.0241	-0.0047
Age: 80 – 84	0.0101	0.0030
Age: 85 and older	0.0122	-0.0184
Less than an 8th grade education	0.0147	-0.0513
Some high school	0.0152	0.0390
High school graduate	0.0000	0.0000
Some college	-0.0174	-0.0368
College graduate	-0.0451	-0.0436
More than a bachelor's degree	-0.0861	-0.0641
General health rating: excellent	0.1082	0.0313
General health rating: very good	0.0623	0.0552
General health rating: good	0.0000	0.0000
General health rating: fair	-0.0744	-0.0488
General health rating: poor	-0.0956	-0.1716
Mental health rating: excellent	0.1989	0.2116
Mental health rating: very good	0.0973	0.1005
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.0560	-0.0609
Mental health rating: poor	-0.0956	-0.1199
Proxy helped	0.0318	0.0089
Proxy answered	0.0170	0.0893
Medicaid dual eligible	0.0019	-0.0222
Low-income subsidy (LIS)	0.0088	-0.0506
Asian survey language	0.0527	-0.1072

Table A-2: Coefficients of Part C Getting Appointments and Care Quickly (C20) CAHPS Measure Composite Items

Predictor	Getting Needed Care as Soon as Wanted	Getting Routine Care as Soon as Wanted	Wait Less Than 15 Minutes
Age: 64 or under	-0.0044	0.0542	-0.0653
Age: 65 – 69	0.0333	0.0009	-0.0177
Age: 70 – 74	0.0000	0.0000	0.0000
Age: 75 – 79	0.0401	0.0218	0.0122
Age: 80 – 84	0.0326	0.0389	-0.0077
Age: 85 and older	0.0710	0.0243	0.0141
Less than an 8th grade education	0.0230	-0.0306	-0.0526
Some high school	0.0125	-0.0357	0.0548
High school graduate	0.0000	0.0000	0.0000
Some college	0.0023	-0.0203	0.0344
College graduate	0.0086	-0.0511	0.0225
More than a bachelor's degree	-0.0137	-0.0717	0.0122
General health rating: excellent	0.1011	0.0186	0.2354
General health rating: very good	0.0425	0.0092	0.0974
General health rating: good	0.0000	0.0000	0.0000
General health rating: fair	-0.0476	-0.0439	-0.0891
General health rating: poor	-0.0857	-0.0784	-0.1452
Mental health rating: excellent	0.1801	0.1525	0.1130
Mental health rating: very good	0.0698	0.0749	0.0421
Mental health rating: good	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0306	-0.0406	-0.0215
Mental health rating: poor	-0.0917	-0.0721	0.0829
Proxy helped	0.0512	-0.0061	-0.0675
Proxy answered	0.0764	0.0762	-0.0235
Medicaid dual eligible	-0.0436	-0.0336	-0.0196
Low-income subsidy (LIS)	0.0031	-0.0299	0.0143
Asian survey language	-0.2210	-0.2959	-0.0893

Table A-3: Coefficients of Part C Customer Service (C21) CAHPS Measure Composite Items

Predictor	Paperwork Easy	Plan Customer Service Gives Information	Plan Customer Service Courtesy and Respect
Age: 64 or under	0.0170	0.0369	-0.0096
Age: 65 – 69	0.0067	0.0112	-0.0096
Age: 70 – 74	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0082	0.0074	-0.0132
Age: 80 – 84	-0.0240	-0.0097	-0.0201
Age: 85 and older	-0.0152	0.0039	0.0036
Less than an 8th grade education	-0.0299	-0.0156	-0.0191
Some high school	-0.0184	-0.0061	-0.0111
High school graduate	0.0000	0.0000	0.0000
Some college	-0.0084	-0.0679	-0.0218
College graduate	-0.0151	-0.0890	-0.0221
More than a bachelor's degree	-0.0392	-0.1450	-0.0353
General health rating: excellent	0.0196	0.0352	0.0266
General health rating: very good	0.0082	0.0461	0.0116
General health rating: good	0.0000	0.0000	0.0000
General health rating: fair	-0.0249	-0.0314	0.0039
General health rating: poor	-0.0321	-0.0346	-0.0327
Mental health rating: excellent	0.0611	0.1837	0.0895
Mental health rating: very good	0.0350	0.0735	0.0397
Mental health rating: good	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0372	-0.0363	-0.0244
Mental health rating: poor	-0.0980	-0.1784	-0.1015
Proxy helped	-0.0749	0.0000	-0.0225
Proxy answered	0.0045	0.0391	0.0029
Medicaid dual eligible	-0.0658	0.0405	-0.0137
Low-income subsidy (LIS)	0.0063	0.0068	0.0222
Asian survey language	-0.1493	-0.0986	-0.1499

Table A-4: Coefficients of Part C Stand-alone CAHPS Measures

Predictor	Paperwork Easy	Plan Customer Service Gives Information	Plan Customer Service Courtesy and Respect
Age: 64 or under	0.0170	0.0369	-0.0096
Age: 65 – 69	0.0067	0.0112	-0.0096
Age: 70 – 74	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0082	0.0074	-0.0132
Age: 80 – 84	-0.0240	-0.0097	-0.0201
Age: 85 and older	-0.0152	0.0039	0.0036
Less than an 8th grade education	-0.0299	-0.0156	-0.0191
Some high school	-0.0184	-0.0061	-0.0111
High school graduate	0.0000	0.0000	0.0000
Some college	-0.0084	-0.0679	-0.0218
College graduate	-0.0151	-0.0890	-0.0221
More than a bachelor's degree	-0.0392	-0.1450	-0.0353
General health rating: excellent	0.0196	0.0352	0.0266
General health rating: very good	0.0082	0.0461	0.0116
General health rating: good	0.0000	0.0000	0.0000
General health rating: fair	-0.0249	-0.0314	0.0039
General health rating: poor	-0.0321	-0.0346	-0.0327
Mental health rating: excellent	0.0611	0.1837	0.0895
Mental health rating: very good	0.0350	0.0735	0.0397
Mental health rating: good	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0372	-0.0363	-0.0244
Mental health rating: poor	-0.0980	-0.1784	-0.1015
Proxy helped	-0.0749	0.0000	-0.0225
Proxy answered	0.0045	0.0391	0.0029
Medicaid dual eligible	-0.0658	0.0405	-0.0137
Low-income subsidy (LIS)	0.0063	0.0068	0.0222
Asian survey language	-0.1493	-0.0986	-0.1499

Table A-5: Coefficients of Part C Care Coordination (C24) CAHPS Measure Composite Items

Predictor	MD/Office Help to Manage Care	MD Informed About Specialist Care	MD Follows up about Test Results and Gives Results as soon as Needed	Talk with MD about Medicines	MD has Medical Records about Care
Age: 64 or under	0.0046	-0.0114	-0.0013	0.0402	-0.0265
Age: 65 – 69	-0.0528	-0.0120	-0.0077	0.0376	-0.0073
Age: 70 – 74	0.0000	0.0000	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0282	0.0151	-0.0080	-0.0344	0.0022
Age: 80 – 84	-0.0190	0.0006	0.0066	-0.1098	-0.0094
Age: 85 and older	-0.0895	-0.0232	-0.0263	-0.1662	-0.0021
Less than an 8th grade education	0.0260	0.1001	-0.0047	0.0194	-0.0268
Some high school	-0.0135	0.0669	0.0250	-0.0074	-0.0330
High school graduate	0.0000	0.0000	0.0000	0.0000	0.0000
Some college	-0.0034	-0.0245	-0.0377	-0.0035	-0.0055
College graduate	-0.0332	-0.0389	-0.0417	-0.0222	-0.0205
More than a bachelor's degree	-0.0216	-0.0856	-0.0365	-0.0587	-0.0065
General health rating: excellent	-0.0008	-0.0270	0.0860	0.1207	-0.0079
General health rating: very good	-0.0111	-0.0040	0.0423	0.0601	0.0247
General health rating: good	0.0000	0.0000	0.0000	0.0000	0.0000
General health rating: fair	-0.0650	-0.0502	-0.0636	-0.0435	-0.0308
General health rating: poor	-0.1020	-0.1222	-0.1524	-0.1039	-0.0726
Mental health rating: excellent	0.1224	0.1946	0.1645	0.1768	0.0931
Mental health rating: very good	0.0304	0.0808	0.0931	0.0867	0.0571
Mental health rating: good	0.0000	0.0000	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0391	-0.1002	-0.0407	-0.0597	-0.0274
Mental health rating: poor	-0.0342	-0.1422	-0.0559	-0.0531	-0.0843
Proxy helped	0.0196	-0.0021	-0.0019	0.0816	-0.0079
Proxy answered	-0.0020	-0.0433	0.0655	0.0710	0.0457
Medicaid dual eligible	-0.0061	0.0613	-0.0082	0.0014	-0.0122
Low-income subsidy (LIS)	-0.0318	0.1438	0.0131	-0.0131	0.0067
Asian survey language	0.1027	-0.1596	0.1903	-0.1308	-0.1026

Table A-6: Coefficients of Part D CAHPS Stand-alone Measures

Predictor	MA-PD D05: Rating of Drug Plan	PDP D05: Rating of Drug Plan
Age: 64 or under	-0.1891	-0.3770
Age: 65 – 69	-0.1095	-0.1195
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.1042	0.1631
Age: 80 – 84	0.1505	0.2597
Age: 85 and older	0.1974	0.5198
Less than an 8th grade education	0.0703	-0.1769
Some high school	0.0425	0.0060
High school graduate	0.0000	0.0000
Some college	-0.2087	-0.3485
College graduate	-0.3306	-0.1539
More than a bachelor's degree	-0.4426	-0.5077
General health rating: excellent	0.2238	0.1233
General health rating: very good	0.1922	0.0239
General health rating: good	0.0000	0.0000
General health rating: fair	-0.1861	-0.2132
General health rating: poor	-0.4147	-0.3450
Mental health rating: excellent	0.3268	0.1120
Mental health rating: very good	0.1035	0.0617
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.1101	-0.2242
Mental health rating: poor	-0.1847	-0.9212
Proxy helped	-0.1628	-0.2064
Proxy answered	-0.0284	0.2563
Medicaid dual eligible	0.3942	0.8442
Low-income subsidy (LIS)	0.3567	0.5929
Asian survey language	-0.3631	0.0000

Table A-7: Coefficients of Part D Getting Needed Prescription Drugs (D06) CAHPS Measure Composite Items

Predictor	MA-PD: Get Needed Prescription Drugs	MA-PD: Get Prescription Drugs from Mail or Pharmacy	PDP: Get Needed Prescription Drugs	PDP: Get Prescription Drugs from Mail or Pharmacy
Age: 64 or under	-0.0603	-0.0276	-0.1955	-0.1288
Age: 65 – 69	-0.0152	-0.0062	-0.0411	-0.0108
Age: 70 – 74	0.0000	0.0000	0.0000	0.0000
Age: 75 – 79	0.0204	0.0136	0.0322	0.0381
Age: 80 – 84	0.0462	0.0168	0.0365	0.0418
Age: 85 and older	0.0138	-0.0005	0.0134	-0.0303
Less than an 8th grade education	-0.0556	-0.0378	-0.0470	-0.0335
Some high school	-0.0062	-0.0187	-0.1264	-0.1132
High school graduate	0.0000	0.0000	0.0000	0.0000
Some college	-0.0375	-0.0425	-0.0692	-0.0427
College graduate	-0.0481	-0.0536	-0.0365	-0.0626
More than a bachelor's degree	-0.0618	-0.0857	-0.1088	-0.1149
General health rating: excellent	0.0306	0.0614	0.0839	0.0712
General health rating: very good	0.0473	0.0425	0.0331	0.0552
General health rating: good	0.0000	0.0000	0.0000	0.0000
General health rating: fair	-0.0529	-0.0442	-0.1217	-0.0695
General health rating: poor	-0.1323	-0.1428	-0.2777	-0.1987
Mental health rating: excellent	0.0988	0.1109	-0.0206	0.0334
Mental health rating: very good	0.0502	0.0555	-0.0026	0.0256
Mental health rating: good	0.0000	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0506	-0.0467	-0.1631	-0.0679
Mental health rating: poor	-0.0532	-0.0254	-0.3480	-0.2465
Proxy helped	-0.0094	0.0049	-0.0014	-0.0612
Proxy answered	0.0294	0.0411	0.1625	0.0613
Medicaid dual eligible	0.0413	0.0149	0.0288	0.0656
Low-income subsidy (LIS)	0.0689	0.0170	0.1885	0.1608
Asian survey language	-0.0583	0.0220	0.0000	0.0000

Attachment B: Calculating Measure Data for the Surviving Contract of a Consolidation

First Year Following a Consolidation

In the first year following a consolidation, the measure values for the surviving contract of a consolidation are calculated as the enrollment-weighted mean of all contracts in the consolidation. The month(s) of enrollment used to calculate the enrollment weighted means varies by the type measure. Table B-1 below lists the enrollment used for each type of measure and the rule followed to determine the month(s) of enrollment. Table B-2 provides an example calculation.

Table B-1: Enrollment Month Used in Calculating Measure Scores for the Surviving Contract of a Consolidation

Type of Measure	Rule for Which Month of Enrollment is Used	Month(s) of Enrollment Used for 2024 Star Ratings
CAHPS	Enrollment at the time survey sample is pulled	January 2023
Call Center	Average enrollment during the study period	Feb 2023 – May 2023
HOS	Enrollment at the time survey sample is pulled	April 2022
HEDIS-HOS	Enrollment at the time survey sample is pulled	April 2022
HEDIS	Enrollment in July of the measurement period	July 2022
All Other Measures	Enrollment in July of the measurement period	July 2022

Table B-2: Example of Calculating the Measure Score for the Surviving Contract of a Consolidation

Contract ID	Surviving or Consumed Contract	Value for Breast Cancer Screening (BCS) Measure	July 2022 Enrollment
HAAAA	Surviving	75.13	43,326
HAAAB	Consumed	50.91	20,933

$$\text{Value for BCS for HAAAA} = \frac{75.13*43,326+50.91*20,933}{43,326+20,933} = 67.24$$

Second Year Following a Consolidation

In the second year following a consolidation, the measure values for the surviving contract of a consolidation are as reported for CAHPS, call center, HOS, and HEDIS measures. For all other measures, the measure values for the surviving contract of a consolidation are calculated as the enrollment weighted mean of all contracts in the consolidation.

Attachment C: National Averages for Part C and D Measures

The tables below contain the average of the average of contract numeric and star values for each measure reported in the 2024 Star Ratings. The averages are calculated after the disaster adjustment has been applied.

Table C-1: National Averages for Part C Measures

Measure ID	Measure Name	Numeric Average	Star Average
C01	Breast Cancer Screening	72%	3.7
C02	Colorectal Cancer Screening	71%	3.7
C03	Annual Flu Vaccine	72%	3.1
C04	Monitoring Physical Activity	50%	3.0
C05	Special Needs Plan (SNP) Care Management	72%	3.4
C06	Care for Older Adults – Medication Review	91%	3.8
C07	Care for Older Adults – Pain Assessment	91%	3.9
C08	Osteoporosis Management in Women who had a Fracture	44%	2.6
C09	Diabetes Care – Eye Exam	72%	3.5
C10	Diabetes Care – Blood Sugar Controlled	79%	3.6
C11	Controlling Blood Pressure	73%	3.4
C12	Reducing the Risk of Falling	56%	2.9
C13	Improving Bladder Control	45%	3.2
C14	Medication Reconciliation Post-Discharge	65%	3.4
C15	Plan All-Cause Readmissions	11%	2.9
C16	Statin Therapy for Patients with Cardiovascular Disease	85%	3.3
C17	Transitions of Care	51%	2.5
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	56%	3.0
C19	Getting Needed Care	80	3.4
C20	Getting Appointments and Care Quickly	77	3.5
C21	Customer Service	90	3.6
C22	Rating of Health Care Quality	86	3.3
C23	Rating of Health Plan	87	3.1
C24	Care Coordination	86	3.6
C25	Complaints about the Health Plan	0.32	3.9
C26	Members Choosing to Leave the Plan	19%	3.6
C27	Health Plan Quality Improvement	Medicare only shows a Star Rating for this topic	3.0
C28	Plan Makes Timely Decisions about Appeals	94%	4.1
C29	Reviewing Appeals Decisions	95%	3.6
C30	Call Center – Foreign Language Interpreter and TTY Availability	93%	4.3

Table C-2: National Averages for Part D Measures

Measure ID	Measure Name	MA-PD Numeric Average	MA-PD Star Average	PDP Numeric Average	PDP Star Average
D01	Call Center – Foreign Language Interpreter and TTY Availability	94%	3.7	94%	3.0
D02	Complaints about the Drug Plan	0.33	3.9	0.05	3.9
D03	Members Choosing to Leave the Plan	19%	3.6	12%	3.8
D04	Drug Plan Quality Improvement	Medicare only shows a Star Rating for this topic	3.4	Medicare only shows a Star Rating for this topic	2.9
D05	Rating of Drug Plan	87	3.2	83	3.4
D06	Getting Needed Prescription Drugs	90	3.5	89	3.5
D07	MPF Price Accuracy	97	3.6	97	3.6
D08	Medication Adherence for Diabetes Medications	86%	3.3	86%	2.6
D09	Medication Adherence for Hypertension (RAS antagonists)	88%	3.4	89%	2.6
D10	Medication Adherence for Cholesterol (Statins)	87%	3.2	87%	3.0
D11	MTM Program Completion Rate for CMR	84%	3.5	56%	3.2
D12	Statin Use in Persons with Diabetes (SUPD)	85%	2.7	82%	2.4

Attachment D: Part C and D Data Time Frames

Table D-1: Part C Measure Data Time Frames

Measure ID	Measure Name	Primary Data Source	Data Time Frame
C01	Breast Cancer Screening	HEDIS	01/01/2022 – 12/31/2022
C02	Colorectal Cancer Screening	HEDIS	01/01/2022 – 12/31/2022
C03	Annual Flu Vaccine	CAHPS	03/2023 – 06/2023
C04	Monitoring Physical Activity	HEDIS-HOS	07/19/2022 – 11/01/2022
C05	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	01/01/2022 – 12/31/2022
C06	Care for Older Adults – Medication Review	HEDIS	01/01/2022 – 12/31/2022
C07	Care for Older Adults – Pain Assessment	HEDIS	01/01/2022 – 12/31/2022
C08	Osteoporosis Management in Women who had a Fracture	HEDIS	01/01/2022 – 12/31/2022
C09	Diabetes Care – Eye Exam	HEDIS	01/01/2022 – 12/31/2022
C10	Diabetes Care – Blood Sugar Controlled	HEDIS	01/01/2022 – 12/31/2022
C11	Controlling Blood Pressure	HEDIS	01/01/2022 – 12/31/2022
C12	Reducing the Risk of Falling	HEDIS-HOS	07/19/2022 – 11/01/2022
C13	Improving Bladder Control	HEDIS-HOS	07/19/2022 – 11/01/2022
C14	Medication Reconciliation Post-Discharge	HEDIS	01/01/2022 – 12/31/2022
C15	Plan All-Cause Readmission	HEDIS	01/01/2022 – 12/31/2022
C16	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	01/01/2022 – 12/31/2022
C17	Transitions of Care	HEDIS	01/01/2022 – 12/31/2022
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS	01/01/2022 – 12/31/2022
C19	Getting Needed Care	CAHPS	03/2023 – 06/2023
C20	Getting Appointments and Care Quickly	CAHPS	03/2023 – 06/2023
C21	Customer Service	CAHPS	03/2023 – 06/2023
C22	Rating of Health Care Quality	CAHPS	03/2023 – 06/2023
C23	Rating of Health Plan	CAHPS	03/2023 – 06/2023
C24	Care Coordination	CAHPS	03/2023 – 06/2023
C25	Complaints about the Health Plan	Complaints Tracking Module (CTM)	01/01/2022 – 12/31/2022
C26	Members Choosing to Leave the Plan	MBDSS	01/01/2022 – 12/31/2022
C27	Health Plan Quality Improvement	Star Ratings	Not Applicable
C28	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE)	01/01/2022 – 12/31/2022
C29	Reviewing Appeals Decisions	Independent Review Entity (IRE)	01/01/2022 – 12/31/2022
C30	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	02/2023 – 05/2023

Table D-2: Part D Measure Data Time Frames

Measure ID	Measure Name	Primary Data Source	Data Time Frame
D01	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	02/2023 – 05/2023
D02	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	01/01/2022 – 12/31/2022
D03	Members Choosing to Leave the Plan	MBDSS	01/01/2022 – 12/31/2022
D04	Drug Plan Quality Improvement	Star Ratings	Not Applicable
D05	Rating of Drug Plan	CAHPS	03/2023 – 06/2023
D06	Getting Needed Prescription Drugs	CAHPS	03/2023 – 06/2023
D07	MPF Price Accuracy	PDE data, MPF Pricing Files	01/01/2022 – 09/30/2022
D08	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) data	01/01/2022 – 12/31/2022
D09	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) data	01/01/2022 – 12/31/2022
D10	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) data	01/01/2022 – 12/31/2022
D11	MTM Program Completion Rate for CMR	Part D Plan Reporting	01/01/2022 – 12/31/2022
D12	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) data	01/01/2022 – 12/31/2022

Attachment E: SNP Measure Scoring Methodologies

1. Medicare Part C Reporting Requirements Measure (C05: SNP Care Management)

Step 1: Start with all contracts that offer at least one SNP plan that was active at any point during contract year 2022.

Step 2: Exclude any contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2023), or that were not required to participate in data validation. This exclusion is consistent with the statement from page 6 of the CY 2022 Medicare Part C Plan Reporting Requirements Technical Specifications Document: "**Note:** If a contract terminates before July 1 in the following year after the contract year (CY) reporting period, the contract is not required to report any data for the respective two years – the CY reporting period, and the following year… If a PBP (Plan) under a contract terminates at any time in the CY reporting period and the contract remains active through July 1 of the following year, the contract must still report data for all PBPs, including the terminated PBP."

This excludes:

- Contracts that terminate on or before 07/01/2023 according to the Contract Info extract

Step 3: After removing contract data excluded above, suppress contract rates based on the following rules:

Section-level DV failure: Contracts that score less than 95% in DV for their CY 2022 SNP Care Reporting Requirements data are listed as "CMS identified issues with this plan's data."

Element-level DV failure: Contracts that score 95% or higher in DV for their CY 2022 SNP Care Reporting Requirements data but that failed at least one of the four data elements (elements A, B, C, and F) are listed as "CMS identified issues with this plan's data."

Small size: Contracts that have not yet been suppressed and have a SNP Care Assessment rate denominator [Number of New Enrollees due for an Initial HRA (Element A) + Number of enrollees eligible for an annual reassessment HRA (Element B)] of fewer than 30 are listed as "No Data Available."

Organizations can view their own plan reporting data validation results in HPMS (https://hpms.cms.gov/). From the home page, select Monitoring | Plan Reporting Data Validation.

Step 4: Calculate the rate for the remaining contract using the formula:

[Number of initial HRAs performed on new enrollees (Element C)

+ Number of annual reassessments performed on enrollees eligible for a reassessment (Element F)]

/ [Number of new enrollees due for an Initial HRA (Element A)

+ Number of enrollees eligible for an annual reassessment HRA (Element B)]

2. NCQA HEDIS Measures - (C06 – C07: Care for Older Adults)

The example NCQA measure combining methodology specifications below are written for two Plan Benefit Package (PBP) submissions, which we distinguish as 1 and 2, but the methodology easily extends to any number of submissions.

Rates are produced for any contract offering a SNP in the ratings year which provided SNP HEDIS data in the measurement year.

Definitions

Let N_1 = The Total Number of Members Eligible for the HEDIS measure in the first PBP ("fixed" and auditable)

Let N_2 = The Total Number of Members Eligible for the HEDIS measure in the second PBP ("fixed" and auditable)

Let P_1 = The estimated rate (mean) for the HEDIS measure in the first PBP (auditable)

Let P_2 = The estimated rate (mean) for the same HEDIS measure in the second PBP (auditable)

Setup Calculations

Based on the above definitions, there are two additional calculations:

Let W_1 = The weight assigned to the first PBP results (estimated, auditable). This is estimated from the formula $W_1 = N_1 / (N_1 + N_2)$

Let W_2 = The weight assigned to the second PBP results (estimated, auditable). This is estimated from the formula $W_2 = N_2 / (N_1 + N_2)$

Pooled Analysis

The pooled result from the two rates (means) is calculated as: $P_{pooled} = W_1 * P_1 + W_2 * P_2$

NOTES:
Weights are based on the eligible member population. While it may be more accurate to remove all excluded members before weighting, NCQA and CMS have chosen not to do this (to simplify the method) for two reasons: 1) the number of exclusions relative to the size of the population should be small, and 2) exclusion rates (as a percentage of the eligible population) should be similar for each PBP and negligibly affect the weights.

If one or more of the submissions has a status of NA, those submissions are dropped and not included in the weighted rate (mean) calculations. If one or more of the submissions has an audit designation of BR or NR (which has been determined to be biased or is not reported by choice of the contract), the rate is set to zero as detailed in the section titled "Handling of Biased, Erroneous and/or Not Reportable (NR) Data" and the average enrollment for the year is used for the eligible population in the PBP. An example is shown in table E-1.

Table E-1: Example Calculation Using Effectiveness of Care Rate

Numeric Example Using an Effectiveness of Care Rate	
# of Total Members Eligible for the HEDIS measure in PBP 1, N_1 =	1500
# of Total Members Eligible for the HEDIS measure in PBP 2, N_2 =	2500
HEDIS Result for PBP 1, Enter as a Proportion between 0 and 1, P_1 =	0.75
HEDIS Result for PBP 2, Enter as a Proportion between 0 and 1, P_2 =	0.5
Setup Calculations - Initialize Some Intermediate Results	
The weight for PBP 1 product estimated by $W_1 = N_1 / (N_1 + N_2)$	0.375
The weight for PBP 2 product estimated by $W_2 = N_2 / (N_1 + N_2)$	0.625
Pooled Results	
$P_{pooled} = W_1 * P_1 + W_2 * P_2$	0.59375

Attachment F: Calculating Measure C15: Plan All-Cause Readmissions

All data are available in the CMS 2023 HEDIS® Public Use File (PUF)[1] and can be looked up by IndicatorKey (row) and Variable name (column).

The calculations below use the Denominator, ObservedCount and ExpectedCount values from the PCR (18-64) indicator (IndicatorKey = 202025_20) and the PCR (65+) indicator (IndicatorKey = 202111_20).

For each contract, calculate the (18+) Denominator, ObservedCount, and ExpectedCount:

Denominator(18+) = Denominator(18-64) + Denominator(65+)
ObservedCount(18+) = ObservedCount(18-64) + ObservedCount(65+)
ExpectedCount(18+) = ExpectedCount(18-64) + ExpectedCount(65+)

Using these (18+) values, calculate the (18+) Observed-over-Expected ratio (OE):

$$OE(18+) = \left(\frac{ObservedCount(18+)}{ExpectedCount(18+)}\right)$$

And the national average of the (18+) Observed Rate:

$$NatAvgObs(18+) = Average\left(\left(\frac{ObservedCount(18+)_1}{Denominator(18+)_1}\right) + \ldots + \left(\frac{ObservedCount(18+)_n}{Denominator(18+)_n}\right)\right)$$

Where 1 through n are all contracts with a (18+) Denominator larger than or equal to 150, and a (18+) OE larger than or equal to 0.2 and less than or equal to 5.0.
For each contract, calculate the Final Rate and convert to percentages:

Final Rate(18+) = OE(18+) x NatAvgObs(18+) x 100

And round to the nearest integer.

Example: Calculating the final rate for Contract 1

Contract	Indicator Key	Denominator	Observed Count	Expected Count
Contract 1	202025_20	214	8	12
Contract 1	202111_20	4,792	641	642
Contract 2	202025_20	225	12	7
Contract 2	202111_20	4,761	688	668
Contract 3	202025_20	573	31	35
Contract 3	202111_20	8,629	1,126	1,070
Contract 4	202025_20	12	0	1
Contract 4	202111_20	533	79	73

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-HEDIS-Public-Use-Files

$$\text{NatAvgObs} = \text{Average}\left(\left(\frac{8+641}{214+4,792}\right) + \left(\frac{12+688}{225+4,761}\right) + \left(\frac{31+1,126}{573+8,629}\right) + \left(\frac{0+79}{12+533}\right)\right)$$

$$\text{NatAvgObs} = 0.135181$$

$$\text{OE Contract 1} = \left(\frac{8+641}{12+642}\right) = 0.992355$$

$$\text{Final Rate Contract 1} = 0.992355 \times 0.135181 \times 100 = 13.41$$

Final Rate reported for Contract 1 = 13%

The actual calculated National Observed Rate used in the 2024 Star Ratings was 0.109719901931738.

Attachment G: Weights Assigned to Individual Performance Measures

Table G-1: Part C Measure Weights

Measure ID	Measure Name	Weighting Category	Part C Summary and MA-PD Overall
C01	Breast Cancer Screening	Process Measure	1
C02	Colorectal Cancer Screening	Process Measure	1
C03	Annual Flu Vaccine	Process Measure	1
C04	Monitoring Physical Activity	Process Measure	1
C05	Special Needs Plan (SNP) Care Management	Process Measure	1
C06	Care for Older Adults – Medication Review	Process Measure	1
C07	Care for Older Adults – Pain Assessment	Process Measure	1
C08	Osteoporosis Management in Women who had a Fracture	Process Measure	1
C09	Diabetes Care – Eye Exam	Process Measure	1
C10	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3
C11	Controlling Blood Pressure	Intermediate Outcome Measure	3
C12	Reducing the Risk of Falling	Process Measure	1
C13	Improving Bladder Control	Process Measure	1
C14	Medication Reconciliation Post-Discharge	Process Measure	1
C15	Plan All-Cause Readmissions	Outcome Measure	1*
C16	Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1
C17	Transitions of Care	Process Measure	1
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Process Measure	1
C19	Getting Needed Care	Patients' Experience and Complaints Measure	4
C20	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	4
C21	Customer Service	Patients' Experience and Complaints Measure	4
C22	Rating of Health Care Quality	Patients' Experience and Complaints Measure	4
C23	Rating of Health Plan	Patients' Experience and Complaints Measure	4
C24	Care Coordination	Patients' Experience and Complaints Measure	4

Measure ID	Measure Name	Weighting Category	Part C Summary and MA-PD Overall
C25	Complaints about the Health Plan	Patients' Experience and Complaints Measure	4
C26	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	4
C27	Health Plan Quality Improvement	Improvement Measure	5
C28	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	4
C29	Reviewing Appeals Decisions	Measures Capturing Access	4
C30	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	4

*Plan All-Cause Readmissions has a weight of 1 for the 2024 Star Ratings because it is considered a new measure.

Table G-2: Part D Measure Weights

Measure ID	Measure Name	Weighting Category	Part D Summary and MA-PD Overall
D01	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	4
D02	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	4
D03	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	4
D04	Drug Plan Quality Improvement	Improvement Measure	5
D05	Rating of Drug Plan	Patients' Experience and Complaints Measure	4
D06	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	4
D07	MPF Price Accuracy	Process Measure	1
D08*	Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3
D09*	Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3
D10*	Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3
D11	MTM Program Completion Rate for CMR	Process Measure	1
D12	Statin Use in Persons with Diabetes (SUPD)	Process Measure	1

*For contracts whose service area only covers Puerto Rico, the weight for each adherence measure is set to zero (0) when calculating the summary and overall rating.

Attachment H: Calculation of Weighted Star Rating and Variance Estimates

The weighted summary (or overall) Star Rating for contract *j* is estimated as:

$$\bar{x}_j = \frac{\sum_{i=1}^{n_j} w_{ij} x_{ij}}{\sum_{i=1}^{n_j} w_{ij}}$$

where n_j is the number of performance measures for which contract *j* is eligible; w_{ij} is the weight assigned to performance measure *i* for contract *j*; and x_{ij} is the measure star for performance measure *i* for contract *j*. The variance of the Star Ratings for each contract $j, s_j^2,$, must also be computed in order to estimate the reward factor (r-Factor):

$$s_j^2 = \frac{n_j}{(n_j - 1)(\sum_{i=1}^{n_j} w_{ij})} \left[\sum_{i=1}^{n_j} w_{ij} \left(x_{ij} - \bar{x}_j\right)^2\right]$$

Thus, the $\bar{x}_j$'s are the new summary (or overall) Star Ratings for the contracts. The variance estimate, s_j^2 , simply replaces the non-weighted variance estimate that was previously used for the r-Factor calculation. For all contracts *j*, $w_{ij} = w_i$ (i.e., the performance measure weights are the same for all contracts when estimating a given Star Rating (Part C or Part D summary or MA-PD overall ratings).

Attachment I: Calculating the Improvement Measure and the Measures Used

Calculating the Improvement Measure

Contracts must have data for at least half of the attainment measures used to calculate the Part C or Part D improvement measure to be eligible to receive a rating in that improvement measure.

The improvement change score was determined for each measure for which a contract was eligible by calculating the difference in measure scores between Star Rating years 2023 and 2024.

For measures where a higher score is better:

Improvement Change Score = Score in 2024 - Score in 2023

For measures where a lower score is better:

Improvement Change Score = Score in 2023 - Score in 2024

An eligible measure was defined as a measure for which a contract was scored in both the 2023 and 2024 Star Ratings, and there were no significant measure specification changes or a regional contract reconfiguration for which only contract data is available from the original contract in one or both years.

For each measure, significant improvement or decline between Star Ratings years 2023 and 2024 was determined by a two-sided t-test at the 0.05 significance level:

$$\text{If } \frac{\text{Improvement Change Score}}{\text{Standard Error of Improvement Change Score}} > 1.96, \text{ then YES = significant improvement}$$

$$\text{If } \frac{\text{Improvement Change Score}}{\text{Standard Error of Improvement Change Score}} < -1.96, \text{ then YES = significant decline}$$

Hold Harmless Provision for Individual Measures: If a contract demonstrated statistically significant decline (at the 0.05 significance level) on an attainment measure for which they received five stars during both the current contract year and the prior contract year, then this measure will be counted as showing no significant change. Measures that are held harmless as described here will be considered eligible for the improvement measure. Net improvement is calculated for each class of measures (e.g., outcome, access, and process) by subtracting the number of significantly declined measures from the number of significantly improved measures.

Net Improvement = Number of significantly improved measures - Number of significantly declined measures

The improvement measure score is calculated for Parts C and D separately by taking a weighted sum of net improvement divided by the weighted sum of the number of eligible measures.

Measures are generally weighted as follows:

Outcome or intermediate outcome measure: Weight of 3

Access or patient experience/complaints measure: Weight of 4

Process measure: Weight of 1

Specific weights for each measure, which may deviate from the general scheme above are described in Attachment G. When the weight of an individual measure changes over the two years of data used, the newer weight value is used in the improvement calculation.

$$\text{Improvement Measure Score} = \frac{\text{Net_Imp_Process} + 3 * \text{Net_Imp_Outcome} + 4 * \text{Net_Imp_PtExp}}{\text{Elig_Process} + 3 * \text{Elig_Outcome} + 4 * \text{Elig_PtExp}}$$

Net_Imp_Process = Net improvement for process measures
Net_Imp_Outcome = Net improvement for outcome and intermediate outcome measures
Net_Imp_PtExp = Net improvement for patient experience/complaints and access measures
Elig_Process = Number of eligible process measures
Elig_Outcome = Number of eligible outcome and intermediate outcome measures
Elig_PtExp = Number of eligible patient experience/complaints and access measures

The improvement measure score is converted into a Star Rating using the clustering method. Conceptually, the clustering algorithm identifies the "gaps" in the data and creates cut points that result in the creation of five categories (one for each Star Rating) such that scores of contracts in the same score category (Star Rating) are as similar as possible, and scores of contracts in different categories are as different as possible. Improvement scores of 0 (equivalent to no net change on the attainment measures included in the improvement measure calculation) will be centered at 3 stars when assigning the improvement measure Star Rating. Then, the remaining contracts are split into two groups and clustered: 1) improvement scores less than zero receive one or two stars on the improvement measure and 2) improvement scores greater than or equal to zero receive 3, 4, or 5 stars.

General Standard Error Formula

Because a contract's score on a given measure in one year is not independent of its score in the next year, the standard error for the improvement change score for each measure is calculated using the standard approach for estimating the variance of the difference between two variables that may not be independent. In particular, the standard error of the improvement change score is calculated using the formula:

$$\sqrt{se(Y_{i2})^2 + se(Y_{i1})^2 - 2 * Cov(Y_{i2}, Y_{i1})}$$

Using measure C01 as an example, the change score standard error is:

$se(Y_{i2})$ Represents the 2024 standard error for contract i on measure C01

$se(Y_{i1})$ Represents the 2023 standard error for contract i on measure C01

Y_{i2} Represents the 2024 rate for contract i on measure C01

Y_{i1} Represents the 2023 rate for contract i on measure C01

cov Represents the covariance between Y_{i2} and Y_{i1} computed using the correlation across all contracts observed at both time points (2024 and 2023). In other words:

$$cov(Y_{i2}, Y_{i1}) = se(Y_{i2}) * se(Y_{i1}) * Corr(Y_{i2}, Y_{i1})$$

where the correlation $Corr(Y_{i2}, Y_{i1})$ is assumed to be the same for all contracts and is computed using data for all contracts. This assumption is needed because only one score is observed for each contract in each year; therefore, it is not possible to compute a contract specific correlation.

Improvement Change Score Standard Error Numerical Example

For measure C03, contract A:

$se(Y_{i2})$ = 2.805

$se(Y_{i1})$ = 3.000

$Corr(Y_{i2}, Y_{i1})$ = 0.901

Improvement change score standard error for measure C03 for contract
A = sqrt ($2.805^2 + 3.000^2 - 2 * 0.901 * 2.805 * 3.000$) = 1.305

Standard Error Formulas (SEF) for Specific Measures

The following formulas are used for calculating the contract-specific standard errors for specific measures in the 2024 Star Ratings. These standard errors are used in calculating the improvement change score standard error.

1. SEF for Measures: C01, C02, C04, C05, C08 – C14, C16, C26, C28 – C30, D01, D03, D08 – D12

$$SE_y = \sqrt{\frac{Score_y * (100 - Score_y)}{Denominator_y}}$$

for y = 2023, 2024
$Denominator_y$ is as defined in the Measure Details section for each measure.

2. SEF for Measures: C06, C07

These measures are rolled up from the plan level to the contract level following the formula outlined in Attachment E: NCQA HEDIS Measures. The standard error at the contract level is calculated as shown below. The specifications are written for two PBP submissions, which we distinguish as 1 and 2, but the methodology easily extends to any number of submissions.

The plan level standard error is calculated as:

$$SE_{yj} = \sqrt{\frac{Score_{yj} * (100 - Score_{yj})}{Denominator_{yj}}}$$

for y = 2023, 2024 and j = Plan 1, Plan 2

The contract level standard error is then calculated as:

Let W_{y1} = The weight assigned to the first PBP results (estimated, auditable) for year y, where y = 2023, 2024. This result is estimated by the formula $W_{y1} = N_{y1} / (N_{y1} + N_{y2})$

Let W_{y2} = The weight assigned to the second PBP results (estimated, auditable) for year y, where y = 2023, 2024. This result is estimated by the formula $W_{y2} = N_{y2} / (N_{y1} + N_{y2})$

$$SE_{yi} = \sqrt{(W_{y1})^2 * (SE_{y1})^2 + (W_{y2})^2 * (SE_{y2})^2}$$

for y = Contract Year 2023, Contract Year 2024 and i = Contract i

3. SEF for Measures: C03, C19 – C24, and D05, D06

The CAHPS measure standard errors for 2023 and 2024 were provided to CMS by the CAHPS contractor following the formulas documented in the CAHPS Macro Manual. The actual values used for each contract are included on the Measure Detail CAHPS page in the HPMS preview area.

4. SEF for Measures C25, D02

$$SE_y = \sqrt{\frac{\text{Total Number of Complaints}_y}{(\text{Average Contract Enrollment}_y)^2}} * \frac{1000*30}{\text{NumDays}}$$

NumDays: 2023 = 365, 2024 = 365

5. SEF for Measure D07

The standard error of the MPF Composite Price Accuracy Score for each contract is calculated by using binomial approximations for each of the component scores (Price Accuracy Score and Claim Percentage Score, as described in Attachment M). Since the MPF Composite Price Accuracy Score is equal to (0.5 x Price Accuracy Score) + (0.5 x Claim Percentage Score), the composite measure's variance (and standard error) is a function of the variance of the Price Accuracy Score, the variance of the Claim Percentage Score, and the covariance between them. We assume that the product of the total PDE cost and the Price Accuracy Score (on a 0-1 scale) follows a binomial distribution, and likewise that the product of the number of PDE claims and the Claim Percentage Score (on a 0-1 scale) also follows a binomial distribution. With these assumptions in place, the standard error of the MPF Composite Accuracy Score is calculated as follows:

1. The contract's component scores, on their original 0-100 scale, have variances calculable using formulas based on the binomial variance assumptions described above, separately for each year y = 2023, 2024.

    a. For the Price Accuracy Score, the variance in year y is represented by

$$Var\left(Price\ Acc.Score_y\right) = \frac{\left(Price\ Acc.Score_y \times \left(100 - Price\ Acc.Score_y\right)\right)}{Total\ PDE\ Cost_y}$$

    b. For the Claim Percentage Score, the variance in year y is represented by

$$Var\left(Claims\ Pct.Score_y\right) = \frac{\left(Claims\ Pct.Score_y \times \left(100 - Claims\ Pct.Score_y\right)\right)}{Number\ of\ PDE\ Claims_y}$$

2. The contract-specific covariance between the component scores, shown as $Cov\left(Price\ Acc.\ Score_y, Claim\ Pct.\ Score_y\right)$ in step 3 below, is calculated as the product of:
    a. the contract-specific standard errors of the two component scores, which are the square roots of the two variance estimates shown above in step 1, and
    b. the correlation between the two component scores estimated based on all contracts.
3. The standard error of the MPF Composite Price Accuracy Score is calculated from the components calculated in steps 1 and 2 as shown below:

$$SE_y = \sqrt{\frac{Var\left(Price\ Acc.\ Score_y\right)}{4} + \frac{Var\left(Claim\ Pct.\ Score_y\right)}{4} + \frac{Cov\left(Price\ Acc.\ Score_y, Claim\ Pct.\ Score_y\right)}{2}}$$

for y = 2023, 2024

Star Ratings Measures Used in the Improvement Measures

Table I-1: Part C Measures Used in the Improvement Measure

Measure ID	Measure Name	Measure Usage	Correlation
C01	Breast Cancer Screening	Included	0.927677
C02	Colorectal Cancer Screening	Included	0.743188
C03	Annual Flu Vaccine	Included	0.903184
C04	Monitoring Physical Activity	Included	0.839155
C05	Special Needs Plan (SNP) Care Management	Included	0.899492
C06	Care for Older Adults – Medication Review	Included	0.507510
C07	Care for Older Adults – Pain Assessment	Included	0.399811
C08	Osteoporosis Management in Women who had a Fracture	Included	0.861517
C09	Diabetes Care – Eye Exam	Included	0.853405
C10	Diabetes Care – Blood Sugar Controlled	Included	0.827107
C11	Controlling Blood Pressure	Included	0.786307
C12	Reducing the Risk of Falling	Included	0.830616
C13	Improving Bladder Control	Included	0.474745
C14	Medication Reconciliation Post-Discharge	Included	0.844615
C15	Plan All-Cause Readmissions	Not Included	-
C16	Statin Therapy for Patients with Cardiovascular Disease	Included	0.681168
C17	Transitions of Care	Not Included	-
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Not Included	-
C19	Getting Needed Care	Included	0.788466
C20	Getting Appointments and Care Quickly	Included	0.798595
C21	Customer Service	Included	0.736046
C22	Rating of Health Care Quality	Included	0.699480
C23	Rating of Health Plan	Included	0.877493
C24	Care Coordination	Included	0.692131
C25	Complaints about the Health Plan	Included	0.871058
C26	Members Choosing to Leave the Plan	Included	0.902728
C27	Health Plan Quality Improvement	Not Included	-
C28	Plan Makes Timely Decisions about Appeals	Included	0.715785
C29	Reviewing Appeals Decisions	Included	0.641752
C30	Call Center – Foreign Language Interpreter and TTY Availability	Included	0.207234

Table I-2: Part D Measures Used in the Improvement Measure

Measure ID	Measure Name	Measure Usage	Correlation
D01	Call Center – Foreign Language Interpreter and TTY Availability	Included	0.179690
D02	Complaints about the Drug Plan	Included	0.873781
D03	Members Choosing to Leave the Plan	Included	0.899679
D04	Drug Plan Quality Improvement	Not Included	-
D05	Rating of Drug Plan	Included	0.863090
D06	Getting Needed Prescription Drugs	Included	0.716532
D07	MPF Price Accuracy	Included	0.660011
D08	Medication Adherence for Diabetes Medications	Included	0.715904
D09	Medication Adherence for Hypertension (RAS antagonists)	Included	0.781854
D10	Medication Adherence for Cholesterol (Statins)	Included	0.829572
D11	MTM Program Completion Rate for CMR	Included	0.847085
D12	Statin Use in Persons with Diabetes (SUPD)	Included	0.833716

Attachment J: Star Ratings Measure History

The tables below cross-reference the measures code in each of the yearly Star Ratings releases. Measure codes that begin with DM are display measures which are posted on CMS.gov on this page: http://go.cms.gov/partcanddstarratings.

Table J-1: Part C Measure History

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
C	Access to Primary Care Doctor Visits	HEDIS		DMC08	DMC09	DMC09	DMC09	DMC09	DMC10	DMC10	DMC11	DMC10	DMC12	DMC12	C11	C13
C	Adult BMI Assessment	HEDIS				C07	C07	C07	C07	C07	C07	C08	C10	C10	C12	DMC05
C	Annual Flu Vaccine	CAHPS	C03	C03	C03	C03	C03	C03	C03	C03	C03	C04	C06	C06	C06	C07
C	Antidepressant Medication Management (6 months)	HEDIS	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03
C	Appropriate Monitoring of Patients Taking Long-term Medications	HEDIS							DMC04	DMC04	DMC05	DMC05	DMC05	DMC05	DMC05	C08
C	Asthma Medication Ratio	HEDIS							DMC18	DMC27						
C	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	C30	C28	C28	DME08	C31	C31	C32	C33
C	Breast Cancer Screening	HEDIS	C01	C01	C01	C01	C01	C01	C01	C01	C01	DMC22	C01	C01	C01	C01
C	Call Answer Timeliness	HEDIS									DMC02	DMC02	DMC02	DMC02	DMC02	DMC02
C	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMC06	DMC06	DMC07	DMC07	DMC07	DMC07	DMC08	DMC08	DMC09		DMC09	DMC09	DMC09	C34
C	Call Center - Calls Disconnected When Customer Calls Health Plan	Call Center Monitoring	DMC09	DMC09	DMC10	DMC10	DMC10	DMC10	DMC11	DMC11	DMC12		DMC15	DMC15		
C	Call Center – CSR Understandability	Call Center Monitoring														
C	Call Center – Foreign Language Interpreter and TTY Availability	Call Center Monitoring	C30	C28	C28	C32	C33	C34	C34	C32	C32		C36	C36	C36	C36
C	Call Center – Information Accuracy	Call Center Monitoring											DMC10	DMC10	DMC10	C35
C	Cardiac Rehabilitation – Achievement	HEDIS	DMC25	DMC29												
C	Cardiac Rehabilitation – Engagement 1	HEDIS	DMC26	DMC30												
C	Cardiac Rehabilitation – Engagement 2	HEDIS	DMC27	DMC31												
C	Cardiac Rehabilitation – Initiation	HEDIS	DMC28	DCM32												
C	Cardiovascular Care – Cholesterol Screening	HEDIS										C02	C03	C03	C03	C03
C	Care Coordination	CAHPS	C24	C22	C22	C26	C27	C28	C27	C25	C25	C28	C29	C29		

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
C	Care for Older Adults – Functional Status Assessment	HEDIS	DMC21	DMC25	DCM25	C10	C10	C10	C10	C10	C10	C11	C12	C12	C14	
C	Care for Older Adults – Medication Review	HEDIS	C06	C06	C06	C09	C09	C09	C09	C09	C09	C10	C11	C11	C13	
C	Care for Older Adults – Pain Assessment	HEDIS	C07	C07	C07	C11	C11	C11	C11	C11	C11	C12	C13	C13	C15	
C	Colorectal Cancer Screening	HEDIS	C02	C02	C02	C02	C02	C02	C02	C02	C02	C01	C02	C02	C02	C02
C	Colorectal Cancer Screening – Age 45-75	HEDIS	DMC29													
C	Complaints about the Health Plan	CTM	C25/D02	C23/D02	C23/D02	C27/ D04	C28/ D04	C29 / D04	C28 / D04	C26 / D04	C26 / D04	C29 / D03	C30 / D04	C30 / D06	C31 / D06	C30
C	Computer use by provider helpful	CAHPS								DMC20	DMC21	DMC20				
C	Computer use made talking to provider easier	CAHPS								DMC21	DMC22	DMC21				
C	Computer used during office visits	CAHPS								DMC19	DMC20	DMC19				
C	Continuous Beta Blocker Treatment	HEDIS	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC04	DMC04	DMC04	DMC04	DMC04	DMC04
C	Controlling Blood Pressure	HEDIS	C11	C12	DMC16	DMC16	DMC17	C16	C16	C16	C16	C18	C19	C19	C21	C19
C	Customer Service	CAHPS	C21	C19	C19	C23	C24	C25	C24	C22	C22	C25	C26	C26	C28	C27
C	Diabetes Care – Blood Sugar Controlled	HEDIS	C10	C11	C11	C15	C15	C15	C15	C15	C15	C16	C17	C17	C19	C17
C	Diabetes Care – Cholesterol Controlled	HEDIS										C17	C18	C18	C20	C18
C	Diabetes Care – Cholesterol Screening	HEDIS										C03	C04	C04	C04	C04
C	Diabetes Care – Eye Exam	HEDIS	C09	C09	C09	C13	C13	C13	C13	C13	C13	C14	C15	C15	C17	C15
C	Diabetes Care – Kidney Disease Monitoring	HEDIS		C10	C10	C14	C14	C14	C14	C14	C14	C15	C16	C16	C18	C16
C	Doctors who Communicate Well	CAHPS	DMC05	DMC05	DMC06	DMC06	DMC06	DMC06	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC08	C25
C	Engagement of Substance Use Disorder (SUD) Treatment	HEDIS	DMC13	DMC13	DMC14	DMC14	DMC14	DMC14	DMC15	DMC15	DMC16	DMC15	DMC19			
C	Enrollment Timeliness	MARx							DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	DMD03
C	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS	C18	DMC15	DMC17	DMC17	DMC18									

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
C	Follow-up visit after Hospital Stay for Mental Illness (within 30 days of Discharge)	HEDIS	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01
C	Getting Appointments and Care Quickly	CAHPS	C20	C18	C18	C22	C23	C24	C23	C21	C21	C24	C25	C25	C27	C26
C	Getting Needed Care	CAHPS	C19	C17	C17	C21	C22	C23	C22	C20	C20	C23	C24	C24	C26	C24
C	Glaucoma Testing	HEDIS											C05	C05	C05	C05
C	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11		
C	Health Plan Quality Improvement	Star Ratings	C27	C25	C25	C29	C30	C31	C31	C29	C29	C31	C33	C33		
C	Hospitalizations for Potentially Preventable Complications	HEDIS	DMC15	DMC14	DMC15	DMC15	DMC15	DMC15	DMC16	DMC24						
C	Improving Bladder Control	HEDIS-HOS	C13	C14	C14	C18	C18	C19	C19	DMC22	DMC23	C20	C21	C21	C23	C22
C	Improving or Maintaining Mental Health	HOS	DMC23	DMC27	DMC27	C05	C05	C05	C05	C05	C05	C06	C08	C08	C09	C10
C	Improving or Maintaining Physical Health	HOS	DMC24	DMC28	DMC28	C04	C04	C04	C04	C04	C04	C05	C07	C07	C08	C09
C	Initiation and Engagement of Substance Use Disorder (SUD) Treatment Average	HEDIS	DMC14													
C	Initiation of Substance Use Disorder (SUD) Treatment	HEDIS	DMC12	DMC12	DMC13	DMC13	DMC13	DMC13	DMC14	DMC14	DMC15	DMC14	DMC18			
C	Kidney Health Evaluation for Patients with Diabetes	HEDIS	DMC22	DMC26												
C	Medication Management for People With Asthma	HEDIS								DMC26						
C	Medication Reconciliation Post-Discharge	HEDIS	C14	C15	C15	C19	C19	C20	C20	DMC23						
C	Members Choosing to Leave the Plan	MBDSS	C26/D03	C24/D03	C24/D03	C28/ D05	C29/ D05	C30 / D05	C29 / D05	C27 / D05	C27 / D05	C30 / D04	C32 / D06	C32 / D08	C33 / D08	DME01
C	Monitoring Physical Activity	HEDIS-HOS	C04	C04	C04	C06	C06	C06	C06	C06	C06	C07	C09	C09	C10	C12
C	Osteoporosis Management in Women who had a Fracture	HEDIS	C08	C08	C08	C12	C12	C12	C12	C12	C12	C13	C14	C14	C16	C14
C	Osteoporosis Testing	HEDIS-HOS			DMC04	DMC04	DMC04	DMC04	DMC05	DMC05	DMC06	DMC06	DMC06	DMC06	DMC06	C11
C	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	HEDIS	DMC11	DMC11	DMC12	DMC12	DMC12	DMC12	DMC13	DMC13	DMC14	DMC13	DMC17			

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
C	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	HEDIS	DMC10	DMC10	DMC11	DMC11	DMC11	DMC11	DMC12	DMC12	DMC13	DMC12	DMC16			
C	Physical Functioning Activities of Daily Living	HOS	DMC20	DMC24												
C	Plan All-Cause Readmissions	HEDIS	C15	DMC21	DMC23	DMC23	C20	C21	C21	C19	C19	C22	C23	C23	C25	
C	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE) / Maximus	C28	C26	C26	C30	C31	C32	C32	C30	C30	C32	C34	C34	C34	C31
C	Pneumonia Vaccine	CAHPS	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC09	DMC09	DMC10	DMC09	DMC11	DMC11	C07	C08
C	Rating of Health Care Quality	CAHPS	C22	C20	C20	C24	C25	C26	C25	C23	C23	C26	C27	C27	C29	C28
C	Rating of Health Plan	CAHPS	C23	C21	C21	C25	C26	C27	C26	C24	C24	C27	C28	C28	C30	C29
C	Reducing the Risk of Falling	HEDIS-HOS	C12	C13	C13	C17	C17	C18	C18	C18	C18	C21	C22	C22	C24	C23
C	Reminders for appointments	CAHPS								DMC16	DMC17	DMC16				
C	Reminders for immunizations	CAHPS								DMC17	DMC18	DMC17				
C	Reminders for screening tests	CAHPS								DMC18	DMC19	DMC18				
C	Reviewing Appeals Decisions	Independent Review Entity (IRE) / Maximus	C29	C27	C27	C31	C32	C33	C33	C31	C31	C33	C35	C35	C35	C32
C	Rheumatoid Arthritis Management	HEDIS			C12	C16	C16	C17	C17	C17	C17	C19	C20	C20	C22	C20
C	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	C05	C05	C05	C08	C08	C08	C08	C08	C08	C09	DMC14	DMC14		
C	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	C16	C16	C16	C20	C21	C22	DMC17	DMC25						
C	Testing to Confirm Chronic Obstructive Pulmonary Disease	HEDIS	DMC04	DMC04	DMC05	DMC05	DMC05	DMC05	DMC06	DMC06	DMC07	DMC07	DMC07	DMC07	DMC07	C21
C	Transitions of Care – Average	HEDIS	C17	DMC20	DMC22	DMC22	DMC23									
C	Transitions of Care – Medication Reconciliation Post-Discharge	HEDIS	DMC16	DMC16	DMC18	DMC18	DMC19									
C	Transitions of Care – Notification of Inpatient Admission	HEDIS	DMC17	DMC17	DMC19	DMC19	DMC20									
C	Transitions of Care – Patient Engagement After Inpatient Discharge	HEDIS	DMC18	DMC18	DMC20	DMC20	DMC21									

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
C	Transitions of Care – Receipt of Discharge Information	HEDIS	DMC19	DMC19	DMC21	DMC21	DMC22									

Table J-2: Part D Measure History

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	Notes
D	4Rx Timeliness	Acumen / OIS (4Rx)													DMD03	D07	
D	Adherence – Proportion of Days Covered	Prescription Drug Event (PDE) Data														DMD07	
D	Antipsychotic Use in Persons with Dementia	Prescription Drug Event (PDE) Data	DMD08	DMD08	DMD08	DMD12	DMD14	DMD16	DMD18								
D	Appeals Auto–Forward	Independent Review Entity (IRE) / Maximus				D02	D02	D02	D02	D02	D02	D01	D02	D03	D03	D05	
D	Appeals Upheld	Independent Review Entity (IRE) / Maximus				D03	D03	D03	D03	D03	D03	D02	D03	D04	D04	D06	
D	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	D06	D06	D06	DME08	D05	D07	D07	D10	
D	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMD02	DMD02	DMD02	DMD04	DMD04	DMD04	DMD04	DMD04	DMD04		DMD04	DMD04	DMD05	D01	
D	Call Center – Calls Disconnected – Pharmacist	Call Center Monitoring															
D	Call Center – Calls Disconnected When Customer Calls Drug Plan	Call Center Monitoring	DMD01	DMD01	DMD01	DMD03	DMD03	DMD03	DMD03	DMD03	DMD03		DMD03	DMD03	DMD04	DMD04	
D	Call Center – CSR Understandability	Call Center Monitoring															
D	Call Center – Foreign Language Interpreter and TTY Availability	Call Center Monitoring	D01	D01	D01	D01	D01	D01	D01	D01	D01		D01	D02	D02	D04	
D	Call Center – Information Accuracy	Call Center Monitoring											DMD05	DMD05	DMD06	D03	
D	Call Center – Pharmacy Hold Time	Call Center Monitoring	DMD04	DMD04	DMD04	DMD08	DMD09	DMD09	DMD09	DMD11	DMD11		DMD15	D01	D01	D02	
D	Complaint Resolution	Complaints Tracking Module (CTM)															
D	Complaints – Enrollment	Complaints Tracking Module (CTM)														D08	
D	Complaints – Other	Complaints Tracking Module (CTM)														D09	

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	Notes
D	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	C25/ D02	C23/ D02	C23/ D02	C27 / D04	C28 / D04	C29 / D04	C28 / D04	C26 / D04	C26 / D04	C29 / D03	C30 / D04	C30 / D06	C31 / D06		
D	Diabetes Medication Dosing	Prescription Drug Event (PDE) Data					DMD06	DMD06	DMD06	DMD06	DMD06	DMD04	DMD07	DMD07	DMD08	DMD06	
D	Diabetes Treatment	Prescription Drug Event (PDE) Data										D10	D12	D15	D14	D17	
D	Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website	Acumen / OIT (LIS Match Rates)				DMD06	DMD07	DMD07	DMD07	DMD07	DMD07	DMD05	DMD08	DMD08	DMD09	D14	
D	Drug Plan Quality Improvement	Star Ratings	D04	D04	D04	D06	D06	D06	D07	D07	D07	D05	D07	D09			
D	Drug-Drug Interactions	Prescription Drug Event (PDE) Data				DMD05	DMD05	DMD05	DMD05	DMD05	DMD05	DMD03	DMD06	DMD06	DMD07	DMD05	
D	Enrollment Timeliness	MARx							DME01	DME01	DME01	DME01	DME01	C37 / D06	D05	DMD03	
D	Formulary Administration Analysis	Part D Sponsor						DMD15	DMD17								
D	Getting Information From Drug Plan	CAHPS								DMD10	DMD10	DMD09	DMD14	D10	D09	D11	
D	Getting Needed Prescription Drugs	CAHPS	D06	D06	D06	D08	D08	D08	D09	D09	D09	D07	D09	D12	D11	D13	
D	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11			
D	High Risk Medication	Prescription Drug Event (PDE) Data					DMD14	DMD14	DMD16	D11	D11	D09	D11	D14	D13	D16	
D	Initial Opioid Prescribing	Prescription Drug Event (PDE) Data	DMD15	DMD15													
D	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Data	D10	D10	D10	D12	D12	D12	D13	D14	D14	D13	D15	D18	D17		
D	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) Data	D08	D08	D08	D10	D10	D10	D11	D12	D12	D11	D13	D16	D15		
D	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) Data	D09	D09	D09	D11	D11	D11	D12	D13	D13	D12	D14	D17	D16		
D	Members Choosing to Leave the Plan	MBDSS	C26/ D03	C24/ D03	C24/ D03	C28 / D05	C29 / D05	C30 / D05	C29 / D05	C27 / D05	C27 / D05	C30 / D04	C32 / D06	C32 / D08	C33 / D08	DME01	
D	MPF – Composite	PDE Data, MPF Pricing Files													D12	D15	B

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	Notes
D	MPF – Stability	PDE Data, MPF Pricing Files	DMD03	DMD03	DMD03	DMD07	DMD08	DMD08	DMD08	DMD08	DMD08	DMD06	DMD10	DMD10			A
D	MPF – Updates	PDE Data, MPF Pricing Files											DMD09	DMD09	DMD10	DMD08	
D	MPF Price Accuracy	PDE Data, MPF Pricing Files	D07	D07	D07	D09	D09	D09	D10	D10	D10	D08	D10	D13			A
D	MTM Program Completion Rate for CMR	Prescription Drug Event (PDE) Data	D11	D11	D11	D13	D13	D13	D14	D15	D15	DMD07	DMD12	DMD12			
D	Persistence to Basal Insulin (PST-INS)	Prescription Drug Event (PDE) Data	DMD16														
D	Plan Submitted Higher Prices for Display on MPF	PDE Data, MPF Pricing Files	DMD05	DMD05	DMD05	DMD09	DMD10	DMD10	DMD10	DMD12	DMD12	DMD10	DMD16				
D	Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	Prescription Drug Event (PDE) Data	DMD13	DMD13	DMD13	DMD20											
D	Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)	Prescription Drug Event (PDE) Data	DMD14	DMD14	DMD14	DMD21											
D	Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes	Fu Associates								DMD09	DMD09	DMD08	DMD13	DMD13			
D	Rating of Drug Plan	CAHPS	D05	D05	D05	D07	D07	D07	D08	D08	D08	D06	D08	D11	D10	D12	
D	Reminders to fill prescriptions	CAHPS	DMD06	DMD06	DMD06	DMD10	DMD11	DMD12	DMD13	DMD15	DMD15	DMD13					
D	Reminders to take medications	CAHPS	DMD07	DMD07	DMD07	DMD11	DMD12	DMD13	DMD14	DMD16	DMD16	DMD14					
D	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Data	D12	D12	D12	D14	D14	D14	DMD15	DMD17							
D	Timely Effectuation of Appeals	Independent Review Entity (IRE) / Maximus				DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	
D	Timely Receipt of Case Files for Appeals	Independent Review Entity (IRE) / Maximus				DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	
D	Transition monitoring	Transition Monitoring Program Analysis						DMD11									D
D	Transition monitoring – failure rate for all other drugs	Transition Monitoring Program Analysis							DMD12	DMD14	DMD14	DMD12					C

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	Notes
D	Transition monitoring – failure rate for drugs within classes of clinical concern	Transition Monitoring Program Analysis							DMD11	DMD13	DMD13	DMD11					C
D	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP)	Prescription Drug Event (PDE) Data				DMD15											
D	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Prescription Drug Event (PDE) Data	DMD11	DMD11	DMD11	DMD18											
D	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	Prescription Drug Event (PDE) Data	DMD12	DMD12	DMD12	DMD19											

Notes:

A: Part of composite measure MPF - Composite in 2011 – 2012

B: Composite measure - combined MPF - Accuracy and MPF Stability

C: Part of composite measure Transition Monitoring - Composite starting in 2019

D: Composite Measure – "Transition monitoring - failure rate for drugs within classes of clinical concern" and "Transition monitoring - failure rate for all other drugs"

Table J-3: Common Part C & Part D Measure History

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
E	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	C30 / D06	C28 / D06	C28 / D06	DME08	C31 / D05	C31 / D07	C32 / D07	C33 / D10
E	Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-Only, PDP)	Disenrollment Reasons Survey	DME04	DME04	DME04	DME04	DME04	DME04	DME05	DME05	DME05	DME05				
E	Disenrollment Reasons - Problems Getting Information and Help from the Plan (MA-PD, PDP)	Disenrollment Reasons Survey	DME06	DME06	DME06	DME06	DME06	DME06	DME07	DME07	DME07	DME07				
E	Disenrollment Reasons - Problems Getting the Plan to Provide and Pay for Needed Care (MA-PD, MA-Only)	Disenrollment Reasons Survey	DME02	DME02	DME02	DME02	DME02	DME02	DME03	DME03	DME03	DME03				
E	Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-Only)	Disenrollment Reasons Survey	DME03	DME03	DME03	DME03	DME03	DME03	DME04	DME04	DME04	DME04				
E	Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)	Disenrollment Reasons Survey	DME05	DME05	DME05	DME05	DME05	DME05	DME06	DME06	DME06	DME06				
E	Enrollment Timeliness	MARx							DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	DMD03
E	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11		

Attachment K: Individual Measure Star Assignment Process

This attachment provides detailed information about the clustering and the relative distribution and significance testing (CAHPS) methodologies used to assign stars to individual measures.

Clustering Methodology Introduction

To separate a distribution of scores into distinct groups or categories, a set of values must be identified to separate one group from another group. The set of values that break the distribution of the scores into non-overlapping groups is the set of cut points.

For each individual measure, CMS determines the measure cut points using the information provided from the hierarchical clustering algorithm in SAS, described in "Clustering Methodology Detail" below. Conceptually, the clustering algorithm identifies the natural gaps that exist within the distribution of the scores and creates groups (clusters) that are then used to identify the cut points that result in the creation of a pre-specified number of categories.

For Star Ratings, the algorithm is run with the goal of determining the four cut points (labeled in the Figure J-1 below as A, B, C, and D) that are used to create the five non-overlapping groups that correspond to each of the Star Ratings (labeled in the diagram below as G1, G2, G3, G4, and G5). For Part D measures, CMS determines MA-PD and PDP cut points separately. Data identified to be biased, erroneous, or excluded by disaster rules are removed from the algorithm. The scores are grouped such that scores within the same Star Rating category are as similar as possible, and scores in different categories are as different as possible.

Figure K-1: Diagram showing gaps in data where cut points are assigned.

As mentioned, the cut points are used to create five non-overlapping groups. The value of the lower bound for each group is included in the category, while the value of the upper bound is not included in the category. CMS does not require the same number of observations (contracts) within each group. The groups are identified such that within a group the measure scores must be similar to each other and between groups, the measure scores in one group are not similar to measure scores in another group. The groups are then used for the conversion of the measure scores to one of five Star Ratings categories. For most measures, a higher score is better, and thus, the group with the highest range of measure scores is converted to a rating of five stars. An example of a measure for which higher is better is *Medication Adherence for Diabetes Medications*. For some measures a lower score is better, and thus, the group with the lowest range of measure scores is converted to a rating of five stars. An example of a measure for which a lower score is better is *Members Choosing to Leave the Plan*.

Example 1 – Clustering Methodology for a Higher is Better measure

Consider the information provided for the cut points for *Medication Adherence for Diabetes Medications* in Table K-1 below. As stated previously, for Part D measures CMS calculates MA-PD and PDP cut points separately (e.g., different cut points are calculated for MA-PD and PDPs). If the MA-PD cut points identified using the clustering algorithm are 80%, 85%, 87%, and 91%; for PDPs, the cut points are 84%, 86%, 88%, and 90%. (The set of values corresponds to the cut points in figure J-2 below as A, B, C, and D and the categories for each of the five Star Ratings are indicated above each group.) Since a measure score can only assume a value between 0% and 100% (including 0% and 100%), the one-star and five-star categories contain only a single value in the table below as the upper or lower bound.

Table K-1: Medication Adherence for Diabetes Medications cut points example: cut points are for illustrative purposes

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 80%	80% to less than 85%	85% to less than 87%	87% to less than 91%	greater than or equal to 91%
PDP	less than 84%	84% to less than 86%	86% to less than 88%	88% to less than 90%	greater than or equal to 90%

Figure K-2: Diagram showing star assignment based cut points.

Since higher is better for *Medication Adherence for Diabetes Medications*, a rating of one star is assigned to all MA-PD measure scores below 80% in this example. For each of the other Star Rating categories, the value of the lower bound is included in the rating category, while the upper bound value is not included. Focusing solely on the cut points for MA-PDs, a rating of two stars is assigned to each measure score that is at least 80% (the first cut point) to less than 85% (the second cut point) in this example. Since measure scores are reported as percentages with no decimal places, any measure score of 80% to 84% would be assigned two stars, while a measure score of 85% would be assigned a rating of three stars. Measure scores that are at least 85% to less than 87% would be assigned a rating of three stars. For a conversion to four stars, a measure score of at least 87% to less than 91% would be needed. A rating of five stars would be assigned to any measure score of 91% or more. PDPs have different cut points, but the same overall rules apply for converting the measure score to a Star Rating.

Example 2 – Clustering Methodology for a Lower is Better measure

Consider the information provided for the cut points for *Members Choosing to Leave the Plan* in Table K-2 below. As stated previously, for Part D measures CMS calculates MA-PD and PDP cut points separately. In the example, the MA-PD cut points for *Members Choosing to Leave the Plan* determined using the clustering algorithm are 44%, 29%, 16%, and 9%; for PDPs, the cut points are 20%, 13%, 19%, and 6%. (These correspond to the cut points in figure J-3 as A, B, C, and D).

Since lower is better for this measure, the five-star category will have the lowest measure score range, while the one-star category will have scores that are highest in value. For each of the other Star Rating categories, the value of the lower bound is not included in the rating category, while the upper bound value is included. (The inclusivity and exclusivity of the upper and lower bounds is opposite for a measure score where lower is better as compared to higher is better.) For MA-PDs, a rating of five stars would be assigned to measure scores of 9% or less. Measure scores that are greater than 9% up to a maximum value of 16% (including a measure score of 16%) would be assigned a rating of four stars. A rating of three stars would be assigned to measure scores greater than 16% up to a maximum value of 29%. A rating of two stars would be assigned to a measure score that is greater than 29% up to and including 44%. A rating of one star would be assigned to any measure score greater than 44%. PDPs have different cut points, but the same overall rules apply for converting the measure score to a Star Rating.

Table K-2: Members Choosing to Leave the Plan cut points example: cut points are for illustrative purposes

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	greater than 44%	greater than 29% to 44%	greater than 16% to 29%	greater than 9% to 16%	less than or equal to 9%
PDP	greater than 20%	greater than13% to 20%	greater than 9% to 13%	greater than 6% to 9%	less than or equal to 6%

Figure J-3: Diagram showing star assignment based on cut points.

Clustering Methodology Detail

This section details the steps of the clustering method performed in SAS to allow the conversion of the measure scores to measure-level stars.

Tukey outlier deletion is used to determine the cut points for all non-CAHPS measures. Tukey outlier deletion involves removing Tukey outer fence outlier contract scores, those defined as measure-specific scores outside the bounds of 3.0 times the measure-specific interquartile range subtracted from the 1st quartile or added to the 3rd quartile. Outliers are removed prior to applying mean resampling to the hierarchical clustering algorithm. The 1st and 3rd quartiles can be obtained by using the MEANS procedure in SAS. The Tukey outer fence outlier cutoffs can then be calculated as:

- Lower outlier cutoff: first quartile – 3.0*(third quartile – first quartile).
- Upper outlier cutoff: third quartile + 3.0*(third quartile – first quartile).

Measures with data displays of percentages with no decimal places ranging from 0 to 100 will have the lower and upper outlier cutoffs capped at those values, respectively. Any other measures with range restrictions, such as have a lower bound of zero, will have the respective outlier cutoff capped at the restricted value.

Mean resampling is used to determine the cut points for all non-CAHPS measures. With mean resampling, measure-specific scores for the current year's Star Ratings are separated into 10 equal-sized groups, using a random assignment process to assign each contract's measure score to a group. The random assignment of contracts into 10 groups can be produced using the SURVEYSELECT procedure in SAS as follows:
proc surveyselect data=inclusterdat groups=10 seed=8675309 out=inclusterdat_random;
run;

In the above code, the input dataset, *inclusterdat*, is the list of contracts without missing, flagged, excluded by disaster rules or voluntary contract scores for a particular measure. The *group=10* option identifies that 10 random groupings of the data should be created. The *seed=8675309* option specifies the seed value that controls the starting point of the random sequence of numbers and allows for future replication of the randomization process. The output dataset, *inclusterdat_random*, is identical to the input dataset with the addition of a new column, named *groupid*, that has the group assignments (from 1 through 10) for each contract.
The hierarchal clustering algorithm (steps 1 through 4 below) is then applied 10 times, each time leaving out one of the 10 groups. For each measure and leave-one-out contract set, the clustering method does the following:

- Produces the individual measure distance matrix.
- Groups the measure scores into an initial set of clusters.
- Selects the set of clusters.

1. **Produce the individual measure distance matrix.**

   For each pair of contracts j and k (j>=k) among the n contracts with measure score data, compute the Euclidian distance of their measure scores (e.g., the absolute value of the difference between the two

measure scores). Enter this distance in row j and column k of a distance matrix with n rows and n columns. This matrix can be produced using the DISTANCE procedure in SAS as follows:

```
proc distance data= inclusterdat  leave1out out=distancedat method=Euclid;
        var interval(measure_score);
        id contract_id;
    run;
```

In the above code, the input data set, *inclusterdat_leave1out*, is the list of contracts (excluding the group left out) without missing, flagged, excluded by disaster rules or voluntary contract scores for a particular measure. Each record has a unique contract identifier, *contract_id*. The option *method=Euclid* specifies that distances between contract measure scores should be based on Euclidean distance. The input data contain a variable called *measure_score* that is formatted to the display criteria outlined in the Technical Notes. In the *var* call, the parentheses around *measure_score* indicate that *measure_score* is considered to be an interval or numeric variable. The distances computed by this code are stored to an output data set called *distancedat.*

2. Create a tree of cluster assignments.

The distance matrix calculated in Step 1 is the input to the clustering procedure. The stored distance algorithm is implemented to compute cluster assignments. The following process is implemented by using the CLUSTER procedure in SAS:

- The input measure score distances are squared.
- The clusters are initialized by assigning each contract to its own cluster.
- In order to determine which pair of clusters to merge, Ward's minimum variance method is used to separate the variance of the measure scores into within-cluster and between-cluster sum of squares components.
- From the existing clusters, two clusters are selected for merging to minimize the within-cluster sum of squares over all possible sets of clusters that might result from a merge.
- Steps 3 and 4 are repeated to reduce the number of clusters by one until a single cluster containing all contracts results.

The result is a data set that contains a tree-like structure of cluster assignments, from which any number of clusters between 1 and the number of contract measure scores could be computed. The SAS code for implementing these steps is:

```
proc cluster data=distancedat method=ward outtree=treedat noprint;
        id contract_id;
    run;
```

The *distancedat* data set containing the Euclidian distances was created in Step 1. The option *method=ward* indicates that Ward's minimum variance method should be used to group clusters. The output data set is denoted with the *outtree* option and is called *treedat.*

3. Select the final set of clusters from the tree of cluster assignments.

The process outlined in Step 2 will produce a tree of cluster assignments, from which the final number of clusters is selected using the TREE procedure in SAS as follows:

```
proc tree data=treedat ncl=NSTARS horizontal out=outclusterdat noprint;
        id contract_id;
```

run;

The input data set, treedat, is created in Step 2 above. The syntax, ncl=NSTARS, denotes the desired final number of clusters (or star levels). For most measures, NSTARS= 5. In cases where multiple clusters have the same score value range those clusters are combined, leading to fewer than 5 clusters. Since the improvement measures have a constraint that contracts with improvement scores of zero or greater are to be assigned at least 3 stars for improvement, the clustering is conducted separately for contract measure scores that are greater than or equal to zero versus those that are less than zero. Specifically, Steps 1-3 are first applied to contracts with improvement scores that meet or exceed zero, in which case NSTARS equals three. The resulting improvement measure stars can take on values of 3, 4, or 5. For those contracts with improvement scores less than zero, Steps 1-3 are applied with NSTARS=2 and these contracts will either receive 1 or 2 stars.

4. Final Thresholds

The cluster assignments produced by the above approach have cluster labels that are unordered. The final step after applying the above steps to all contract measure scores is to order the cluster labels so that the 5-star category reflects the cluster with the best performance and the 1-star category reflects the cluster with the worst performance. With the exception of the improvement measures which are assigned lower thresholds of zero for the 3-star category, the measure thresholds are defined by examining the range of measure scores within each of the final clusters. The lower limit of each cluster becomes the cut point for the star categories.

Determining Stars from Scores and Thresholds

The mean-resampling approach results in 10 sets of measure-specific cut points, one for each of the 10 implementations of the hierarchical clustering algorithm. For higher-is-better measures, the minimum score observed in each star category defines the effective cut points for the star categories. For lower-is-better measures, the maximum score observed in each star category defines the effective cut points for the star categories. These cut points are calculated after the application of Tukey outlier deletion. The final set of estimated thresholds are then calculated as the mean cut point for each threshold per measure from the 10 different cut point values. Tables K-3 and K-4 show the mean resampling final estimated thresholds for the 2024 Star Ratings. Tables K-5 and K-6 show the upper and lower Tukey outlier cutoffs.

Table K-3: 2024 Star Ratings Part C non-CAHPS Measure Mean Resampling Estimated Thresholds

Measure ID	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C01	less than 52%	52% to less than 63%	63% to less than 71%	71% to less than 79%	greater than or equal to 79%
C02	less than 48%	48% to less than 60%	60% to less than 71%	71% to less than 80%	greater than or equal to 80%
C04	less than 42%	42% to less than 48%	48% to less than 53%	53% to less than 58%	greater than or equal to 58%
C05	less than 42%	42% to less than 55%	55% to less than 74%	74% to less than 85%	greater than or equal to 85%
C06	less than 72%	72% to less than 84%	84% to less than 93%	93% to less than 98%	greater than or equal to 98%
C07	less than 74%	74% to less than 83%	83% to less than 91%	91% to less than 96%	greater than or equal to 96%
C08	less than 28%	28% to less than 39%	39% to less than 50%	50% to less than 60%	greater than or equal to 60%
C09	less than 53%	53% to less than 65%	65% to less than 73%	73% to less than 81%	greater than or equal to 81%
C10	less than 57%	57% to less than 72%	72% to less than 80%	80% to less than 87%	greater than or equal to 87%
C11	less than 58%	58% to less than 68%	68% to less than 74%	74% to less than 82%	greater than or equal to 82%
C12	less than 47%	47% to less than 53%	53% to less than 60%	60% to less than 70%	greater than or equal to 70%
C13	less than 38%	38% to less than 42%	42% to less than 47%	47% to less than 51%	greater than or equal to 51%
C14	less than 31%	31% to less than 51%	51% to less than 68%	68% to less than 82%	greater than or equal to 82%
C15	greater than 13%	greater than 11% to 13%	greater than 10% to 11%	greater than 8% to 10%	less than or equal to 8%
C16	less than 79%	79% to less than 84%	84% to less than 86%	86% to less than 90%	greater than or equal to 90%
C17	less than 40%	40 % to less than 52 %	52% to less than 64%	64% to less than 78%	greater than or equal to 78%
C18	less than 44%	44% to less than 53%	53% to less than 60%	60% to less than 68%	greater than or equal to 68%
C25	greater than 1	greater than 0.6 to 1	greater than 0.33 to 0.6	greater than 0.14 to 0.33	less than or equal to 0.14
C26	greater than 41%	greater than 29% to 41%	greater than 18% to 29%	greater than 10% to 18%	less than or equal to 10%
C27	less than -0.246067	-0.246067 to less than 0	0 to less than 0.173502	0.173502 to less than 0.393451	greater than or equal to 0.393451
C28	less than 77%	77% to less than 86%	86% to less than 94%	94% to less than 98%	greater than or equal to 98%
C29	less than 87%	87% to less than 92%	92% to less than 96%	96% to less than 100%	greater than or equal to 100%
C30	less than 87%	87% to less than 90%	90% to less than 94%	94% to less than 97%	greater than or equal to 97%

Notes: These are not the final thresholds for the 2024 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table K-4: 2024 Star Ratings Part D non-CAHPS Measure Mean Resampling Estimated Thresholds

Measure ID	Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
D01	MA-PD	less than 85%	85% to less than 91%	91% to less than 96%	96% to less than 99%	greater than or equal to 99%
D01	PDP	less than 95%	95% to less than 97%	97% to less than 98%	98% to less than100%	greater than or equal to 100%
D02	MA-PD	greater than 1	less than 0.6 to 1	greater than 0.33 to 0.6	greater than 0.14 to 0.33	less than or equal to 0.14
D02	PDP	greater than 0.12	greater than 0.08 to 0.12	greater than 0.05 to 0.08	greater than 0.02 to 0.05	less than or equal to 0.02
D03	MA-PD	greater than 41%	greater than 29% to 41%	greater than 18% to 29%	greater than 10% to 18%	less than or equal to 10%
D03	PDP	greater than 25%	greater than 17% to 25%	greater than 11% to 17%	greater than 7% to 11%	less than or equal to 7%
D04	MA-PD	less than -0.253472	-0.253472 to less than 0	0 to less than 0.193739	0.193739 to less than 0.458889	greater than or equal to 0.458889
D04	PDP	less than -0.123026	-0.123026 to less than 0	0 to less than 0.214538	0.214538 to less than 0.401223	greater than or equal to 0.401223
D07	MA-PD	less than 94	94 to less than 96	96 to less than 98	98 to less than 99	greater than or equal to 99
D07	PDP	less than 96	96 to less than 97	97 to less than 98	98 to less than 99	greater than or equal to 99
D08	MA-PD	less than 80%	80% to less than 84%	84% to less than 88%	88% to less than 90%	greater than or equal to 90%
D08	PDP	less than 84%	84% to less than 87%	87% to less than 89%	89% to less than 93%	greater than or equal to 93%
D09	MA-PD	less than 82%	82% to less than 86%	86% to less than 89%	89% to less than 91%	greater than or equal to 91%
D09	PDP	less than 87%	87% to less than 89%	89% to less than 91%	91% to less than 94%	greater than or equal to 94%
D10	MA-PD	less than 82%	82% to less than 86%	86% to less than 88%	88% to less than 91%	greater than or equal to 91%
D10	PDP	less than 84%	84% to less than 87%	87% to less than 89%	89% to less than 93%	greater than or equal to 93%
D11	MA-PD	less than 67%	67% to less than 77%	77% to less than 85%	85% to less than 92%	greater than or equal to 92%
D11	PDP	less than 34%	34% to less than 52%	52% to less than 63%	63% to less than 77%	greater than or equal to 77%
D12	MA-PD	less than 81%	81% to less than 86%	86% to less than 88%	88% to less than 92%	greater than or equal to 92%
D12	PDP	less than 81%	81% to less than 83%	83% to less than 85%	85% to less than 87%	greater than or equal to 87%

Notes: These are not the final thresholds for the 2024 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table K-5: 2024 Star Ratings Part C non-CAHPS Measure Tukey Outlier Cutoffs

Measure ID	Lower Cutoff	Upper Cutoff
C01	30	100
C02	26	100
C04	25	74
C05	0	100
C06	59	100
C07	57	100
C08	0	100
C09	27	100
C10	38	100
C11	38	100
C12	27	83
C13	24	66
C14	0	100
C15	4	18
C16	71	99
C17	0	100
C18	28	84
C25	0	1.41
C26	0	87.5
C27 (improve)	0	0.807245
C27 (decline)	-0.726192	0
C28	70	100
C29	78	100
C30	82	100

Notes: If the calculated lower or upper outer fence exceeds the minimum or maximum range of the measure, then the minimum or maximum measure score is shown in the table. This means that no outliers were identified at that end of the measure score range. For C27 (decline) group, the upper cut off is technically the lowest value below zero since zero is included in the C27 (improved) group.

Table K-6: 2024 Star Ratings Part D non-CAHPS Measure Tukey Outlier Cutoffs

Measure ID	Type	Lower Cutoff	Upper Cutoff
D01	MA-PD	74	100
D02	MA-PD	0	1.41
D03	MA-PD	0	87.5
D04 (improve)	MA-PD	0	1.297044
D04 (decline)	MA-PD	-0.7343755	0
D07	MA-PD	91	105
D08	MA-PD	72	100
D09	MA-PD	74	100
D10	MA-PD	73	100
D11	MA-PD	53	100
D12	MA-PD	68	100
D01	PDP	86	100
D02	PDP	0	0.26
D03	PDP	0	62
D04 (improve)	PDP	0	0.96875
D04 (decline)	PDP	-1.130433	0
D07	PDP	94	101
D08	PDP	76	97
D09	PDP	80	97.5
D10	PDP	77	98
D11	PDP	0	100
D12	PDP	72	93

Note: If the calculated lower or upper outer fence exceeds the minimum or maximum range of the measure, then the minimum or maximum measure score is shown in the table. This means that no outliers were identified at that end of the measure score range. For D04 (decline) group, the upper cut off is technically the lowest value below zero since zero is included in the D04 (improved) group.

Guardrails are then applied to all non-CAHPS measures, with a few exceptions. Guardrails are not applied to the Part C and Part D improvement measures. Additionally, guardrails are not applied to new measures that have been in the Part C and D Star Rating program for 3 years or less. Cut points for these new measures and improvement measures are based on the hierarchal clustering methodology with mean resampling. When applying guardrails, the difference between the current year and prior year's cut point is calculated for each of the 1 to 5 star levels. A cap value is then calculated and compared to the observed threshold difference.

- For measures having a 0 to 100 scale, an absolute percentage cap of 5 percentage point is applied.
  - If the absolute difference between the current and prior year's cut point is less than or equal to 5 percentage points, the current year's cut point is used as the final cut point value.
  - If the absolute difference between the current and prior year's cut point is greater than 5 percentage points, a 5 percentage point cap is applied. That is, 5 percentage points are added to or subtracted

from the prior year's cut point value (depending on the direction of movement for the cut point value in the current year) to obtain the final cut point value for the current year.

- For measures not having a 0 to 100 scale, a restricted range cap of 5 percent of the prior year's score range is applied. Specifically, the restricted range cap is equal to the prior year's (maximum score value – minimum score value) * 0.05.
  - If the absolute difference between the current and prior year's is less than or equal to the calculated restricted range cap value, the current year's cut point is used as the final cut point value.
  - If the absolute difference between the current and prior year's is greater than the calculated restricted range cap value, then the restricted range cap is applied. That is, the calculated restricted range cap value is added to or subtracted from the prior year's cut point value (depending on the direction of the movement of the cut point value in the current year) to obtain the final cut point value for the current year.

When we proposed and finalized Tukey outlier deletion in the 2021 final rule (CMS–4190–F), we described that in the first year of adding Tukey outlier deletion, the prior year's thresholds would be rerun, including mean resampling and Tukey outer fence deletion so that the guardrails would be applied such that there is consistency between the years. For the purposes of calculating the guardrails for the 2024 Star Ratings, the 2023 Star Ratings cut points were rerun including mean resampling, Tukey outlier deletion and no guardrails. These rerun 2023 Star Ratings cut points serve as the basis for applying the guardrails for the 2024 Star Ratings and are shown in Tables K-7 and K-8.

Table K-7: 2023 Star Ratings Part C Mean Resampling and Tukey Outlier Deletion Non-CAHPS Measure Thresholds

Measure ID	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C01	less than 50%	50% to less than 63%	63% to less than 71%	71% to less than 76%	greater than or equal to 76%
C02	less than 55%	55% to less than 66%	66% to less than 74%	74% to less than 81%	greater than or equal to 81%
C04	less than 44%	44% to less than 49%	49% to less than 53%	53% to less than 57%	greater than or equal to 57%
C05	less than 46%	46% to less than 62%	62% to less than 75%	75% to less than 85%	greater than or equal to 85%
C06	less than 73%	73% to less than 82%	82% to less than 91%	91% to less than 96%	greater than or equal to 96%
C07	less than 73%	73% to less than 83%	83% to less than 89%	89% to less than 95%	greater than or equal to 95%
C08	less than 34%	34% to less than 47%	47% to less than 60%	60% to less than 76%	greater than or equal to 76%
C09	less than 47%	47% to less than 61%	61% to less than 71%	71% to less than 79%	greater than or equal to 79%
C10	less than 63%	63% to less than 72%	72% to less than 80%	80% to less than 86%	greater than or equal to 86%
C12	less than 46%	46 % to less than 53 %	53% to less than 60%	60% to less than 69%	greater than or equal to 69%
C13	less than 39%	39 % to less than 43 %	43% to less than 48%	48% to less than 53%	greater than or equal to 53%
C14	less than 43%	43 % to less than 57 %	57% to less than 69%	69% to less than 82%	greater than or equal to 82%
C16	less than 79%	79% to less than 84%	84% to less than 86%	86% to less than 89%	greater than or equal to 89%
C25	greater than 0.68	greater than 0.68 to 0.43	greater than 0.43 to 0.25	greater than 0.25 to 0.12	less than or equal to 0.12
C26	less than 37%	37% to less than 24%	24% to less than 15%	15% to less than 7%	greater than or equal to 7%
C28	less than 89%	89% to less than 93%	93% to less than 97%	97% to less than 100%	equal to 100%
C29	less than 84%	84% to less than 90%	90% to less than 95%	95% to less than 98%	greater than or equal to 98%
C30	less than 67%	67% to less than 78%	78% to less than 87%	87% to less than 94%	greater than or equal to 94%

Table K-8: 2023 Star Ratings Part D Mean Resampling and Tukey Outlier Deletion Non-CAHPS Measure Thresholds

Measure ID	Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
D01	MA-PD	less than 68%	68% to less than 81%	81% to less than 91%	91% to less than 97%	greater than or equal to 97%
D01	PDP	less than 86%	86% to less than 92%	92% to less than 97%	97% to less than 100%	equal to 100%
D02	MA-PD	greater than 0.68	greater than 0.68 to 0.43	greater than 0.43 to 0.25	greater than 0.25 to 0.12	less than or equal to 0.12
D02	PDP	greater than 0.15	greater than 0.15 to 0.1	greater than 0.1 to 0.07	greater than 0.07 to 0.03	less than or equal to 0.03
D03	MA-PD	greater than 37%	greater than 37% to 24%	greater than 24% to 15%	greater than 15 % to 7%	less than or equal to 7%
D03	PDP	greater than 18%	greater than 18% to13%	greater than 13% to 9%	greater than 9% to 5%	less than or equal to 5%
D08	MA-PD	less than 81%	81% to less than 85%	85% to less than 88%	88% to less than 92%	greater than or equal to 92%
D08	PDP	less than 84%	84% to less than 86%	86% to less than 88%	88% to less than 90%	greater than or equal to 90%
D09	MA-PD	less than 83%	83% to less than 86%	86% to less than 89%	89% to less than 91%	greater than or equal to 91%
D09	PDP	less than 86%	86% to less than 88%	88% to less than 89%	89% to less than 91%	greater than or equal to 91%
D10	MA-PD	less than 81%	81% to less than 85%	85% to less than 88%	88% to less than 92%	greater than or equal to 92%
D10	PDP	less than 86%	86% to less than 87%	87% to less than 88%	88% to less than 90%	greater than or equal to 90%
D11	MA-PD	less than 68%	68% to less than 78%	78% to less than 84 %	84% to less than 91%	greater than or equal to 91%
D11	PDP	less than 34%	34% to less than 49%	49% to less than 62%	62% to less than 78%	greater than or equal to 78%
D12	MA-PD	less than 80%	80% to less than 84%	84% to less than 86%	86% to less than 90%	greater than or equal to 90%
D12	PDP	less than 80%	80% to less than 82%	82% to less than 84%	84% to less than 86%	greater than or equal to 86%

Relative Distribution and Significance Testing (CAHPS) Methodology

The CAHPS measures are case-mix adjusted to take into account differences in the characteristics of enrollees across contracts that may potentially impact survey responses. See Attachment A for the case-mix adjusters. The percentile cut points for base groups are defined by current-year distribution of case-mix adjusted contract means. Percentile cut points are rounded to the nearest integer on the 0-100 reporting scale, and each base group includes those contracts whose rounded mean score is at or above the lower limit and below the upper limit. The number of stars assigned is determined by the position of the contract mean score relative to percentile cutoffs from the distribution of contract weighted mean scores from all contracts (which determines the base group); statistical significance of the difference of the contract mean from the national mean along with the direction of the difference; the statistical reliability of the estimate (based on the ratio of sampling variation for each contract mean to between-contract variation); and the standard error of the mean score. All statistical tests, including comparisons involving standard errors, are computed using unrounded scores.

CAHPS reliability calculation details are provided under the section header, "MA & PDP CAHPS Between-Contract Variances for Reported Measures" at https://www.ma-pdpcahps.org/en/scoring-and-star-ratings. Tables K-9 and K-10 contain the rules applied to determine the final CAHPS measure star value.

Table K-9: CAHPS Star Assignment Rules

Star	Criteria for Assigning Star Ratings
1	A contract is assigned one star if both criteria (a) and (b) are met plus at least one of criteria (c) and (d): (a) its average CAHPS measure score is lower than the 15th percentile; AND (b) its average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score; (c) the reliability is not low; OR (d) its average CAHPS measure score is more than one standard error (SE) below the 15th percentile.
2	A contract is assigned two stars if it does not meet the one-star criteria and meets at least one of these three criteria: (a) its average CAHPS measure score is lower than the 30th percentile and the measure does not have low reliability; OR (b) its average CAHPS measure score is lower than the 15th percentile and the measure has low reliability; OR (c) its average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score and below the 60th percentile.
3	A contract is assigned three stars if it meets at least one of these three criteria: (a) its average CAHPS measure score is at or above the 30th percentile and lower than the 60th percentile, AND it is not statistically significantly different from the national average CAHPS measure score; OR (b) its average CAHPS measure score is at or above the 15th percentile and lower than the 30th percentile, AND the reliability is low, AND the score is not statistically significantly lower than the national average CAHPS measure score; OR (c) its average CAHPS measure score is at or above the 60th percentile and lower than the 80th percentile, AND the reliability is low, AND the score is not statistically significantly higher than the national average CAHPS measure score.
4	A contract is assigned four stars if it does not meet the five-star criteria and meets at least one of these three criteria: (a) its average CAHPS measure score is at or above the 60th percentile and the measure does not have low reliability; OR (b) its average CAHPS measure score is at or above the 80th percentile and the measure has low reliability; OR (c) its average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score and above the 30th percentile.
5	A contract is assigned five stars if both criteria (a) and (b) are met plus at least one of criteria (c) and (d): (a) its average CAHPS measure score is at or above the 80th percentile; AND (b) its average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score; (c) the reliability is not low; OR (d) its average CAHPS measure score is more than one standard error (SE) above the 80th percentile.

Table K-10: CAHPS Star Assignment Alternate Representation

Mean Score	Base Group	Signif. below avg., low reliability	Signif. below avg., not low reliability	Not signif. diff. from avg., low reliability	Not signif. diff. from avg., not low reliability	Signif. above avg., low reliability	Signif. above avg., not low reliability
less than 15th percentile by greater than 1 SE	1	1	1	2	2	2	2
less than 15th percentile by less than or equal to 1 SE		2	1	2	2	2	2
greater than or equal to 15th to less than 30th percentile	2	2	2	3	2	3	2
greater than or equal to 30th to less than 60th percentile	3	2	2	3	3	4	4
greater than or equal to 60th to less than 80th percentile	4	3	4	3	4	4	4
greater than or equal to 80th percentile by less than or equal to 1 SE	5	4	4	4	4	4	5
greater than or equal to 80th percentile by greater than 1 SE		4	4	4	4	5	5

Notes: If reliability is very low (<0.60), the contract does not receive a Star Rating. Low reliability scores are defined as those with at least 11 respondents and reliability ≥0.60 but <0.75 and also in the lowest 12% of contracts ordered by reliability. The SE is considered when the measure score is below the 15th percentile (in base group 1), significantly below average, and has low reliability: in this case, 1 star is assigned if and only if the measure score is at least 1 SE below the unrounded base group 1/2 cut point. Similarly, the SE is considered when the measure score is at or above the 80th percentile (in base group 5), significantly above average, and has low reliability: in this case, 5 stars are assigned if and only if the measure score is at least 1 SE above the unrounded base group 4/5 cut point.
For example, a contract in base group 4 that was not significantly different from average and had low reliability would receive 3 final stars.

As noted above, low reliability scores for CAHPS measures are defined as those with at least 11 respondents and reliability ≥0.60 but <0.75 and also in the lowest 12% of contracts ordered by reliability. Table K-11 contains the 12% reliability cutoffs.

Table K-11: CAHPS Measure 12% Reliability Cutoffs

Measure	12% Reliability Cutoff
Annual Flu Vaccine	0.853836*
Getting Needed Care	0.751402*
Getting Appointments and Care Quickly	0.722606
Customer Service	0.634544
Rating of Health Care Quality	0.655488
Rating of Health Plan	0.828638*
Care Coordination	0.636025
Rating of Drug Plan (MA-PD)	0.787018*
Getting Needed Prescription Drugs (MA-PD)	0.628637
Rating of Drug Plan (PDP)	0.950305*
Getting Needed Prescription Drugs (PDP)	0.833025*

*Note: Reliabilities must be ≥0.60 but <0.75 and also in the lowest 12% of contracts ordered by reliability to be designated as low reliability, thus these cutoffs did not affect low reliability designation.

Attachment L: Medication Adherence Measure Calculations

Part D sponsors currently have access to monthly Patient Safety Reports via the Patient Safety Analysis Web Portal to compare their performance to overall rates and monitor their progress in improving the Part D patient safety measures over time. Sponsors may use the website to view and download the reports for performance monitoring.

Report User Guides are available on the Patient Safety Analysis Web Portal under Help Documents and provide detailed information about the measure calculations and reports. The following information is an excerpt from the Adherence Measures Report Guide (Appendices A and B) and illustrates the days covered calculation and the modification for inpatient stays and skilled nursing facility stays.

Proportion of Days Covered Calculation

In calculating the Proportion of Days Covered (PDC), we first count the number of days the patient was "covered" by at least one drug in the target drug class. The number of days is based on the prescription fill date and days' supply. PDC is calculated by dividing the number of covered days by the number of days in the measurement period. Both of these numbers may be adjusted for IP/SNF stays, as described in the 'Calculating the PDC Adjustment for IP Stays and SNF Stays' section that follows.

Example 1: Non-Overlapping Fills of Two Different Drugs

In this example, a beneficiary fills Benazepril and Captopril, two drugs in the RAS antagonist hypertension target drug class. The covered days do not overlap, meaning the beneficiary filled the Captopril prescription after the days' supply for the Benazepril medication ended.

Table L-1: No Adjustment

	January		February		March	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022
Benazepril	15	16	15	13		
Captopril					15	16

PDC Calculation
Covered Days: 90
Measurement Period: 90
PDC: 90/90 = 100%

Example 2: Overlapping Fills of the Same Generic Ingredient across Single and Combination Products

In this example, a beneficiary fills a drug with the same target generic ingredient prior to the end of the days' supply of the first fill. In rows one and two, there is an overlap between a single and combination drug product, both containing Lisinopril. For this scenario, the overlapping days are shifted because the combination drug product includes the targeted generic ingredient. An adjustment is made to the PDC to account for the overlap in days covered.

In rows two and three, there is an overlap between two combination drug products, both containing Hydrochlorothiazide. However, Hydrochlorothiazide is not a RAS antagonist or targeted generic ingredient, so this overlap is not shifted.

Table L-2: Before Overlap Adjustment

	January		February		March	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022
Lisinopril	15	16				
Lisinopril & HCTZ		16	15			
Benazepril & HCTZ			15	13		

PDC Calculation
Covered Days: 59
Measurement Period: 90
PDC: 59/90 = 66%

Table L-3: After Overlap Adjustment

	January		February		March	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022
Lisinopril	15	16				
Lisinopril & HCTZ			15	13	3	
Benazepril & HCTZ			15	13		

PDC Calculation
Covered Days: 62
Measurement Period: 90
PDC: 62/90 = 69%

Example 3: Overlapping Fills of the Same and Different Target Drugs
In this example, a beneficiary is refilling both Lisinopril and Captopril. When a single and combination product both containing Lisinopril overlap, there is an adjustment to the PDC. When Lisinopril overlaps with Captopril, we do not make any adjustment to the days covered.

Table L-4: Before Overlap Adjustment

	January		February		March		April	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022	4/1/2022	4/16/2022
Lisinopril	15	16						
Lisinopril & HCTZ		16	15					
Captopril					15	16		
Lisinopril						16	15	

PDC Calculation
Covered Days: 92
Measurement Period: 120
PDC: 92/120: 77%

Table L-5: After Overlap Adjustment

	January		February		March		April	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022	4/1/2022	4/16/2022
Lisinopril	15	16						
Lisinopril & HCTZ			15	13	3			
Captopril					15	16		
Lisinopril						16	15	

PDC Calculation
Covered Days: 105
Measurement Period: 120
PDC: 105/120: 88%

PDC Adjustment for Inpatient, and Skilled Nursing Facility Stays Examples

In response to Part D sponsor feedback, CMS modified the PDC calculation, starting with the 2013 Star Ratings (using 2011 PDE data) to adjust for beneficiary stays in inpatient (IP) facilities, and with the 2015 Star Ratings (using 2013 PDE data) to also adjust for hospice enrollments and beneficiary stays in skilled nursing facilities (SNF). These adjustments account for periods that the Part D sponsor would not be responsible for providing prescription fills for targeted medications or more accurately reflect drugs covered under the hospice benefit or waived through the beneficiary's hospice election; thus, their medication fills during an IP or SNF stay or during hospice enrollment would not be included in the PDE claims used to calculate the Patient Safety adherence measures.

The PDC modification for IP stays, hospice enrollments, and SNF stays reflects this situation. Please note that while this modification will enhance the adherence measure calculation, extensive testing indicates that most Part D contracts will experience a negligible impact on their adherence rates. On average, the 2011 adherence rates increased 0.4 to 0.6 percentage points due to the inpatient stay adjustment, and the adjustment may impact the rates positively or negatively.

The hospice and SNF adjustments were tested on 2013 PDE data and overall increased the rates by 0.13 to 0.15 percentage points and 0.29 to 0.35 percentage points, respectively. Hospice information from the Medicare Enrollment Database (EDB) and inpatient claims from the Common Working File (CWF) are available for both PDPs and MA-PDs. SNF claims from the CWF have been used to adjust the SNF PDC adjustments for PDPs. Starting in the 2019 measurement year, when available for MA-PDs in the CWF, adjust the SNF PDC adjustments. Additionally, starting in 2019 measurement year, when available for MA-PDs in the encounter data, adjust for SNF/IP stays for MA-PD beneficiaries. Additionally, starting in 2020 measurement year, when available for MA-PDs in the encounter data, adjust for SNF/IP stays for MA-PD beneficiaries.

Note: Hospice enrollment is no longer a PDC adjustment but rather an exclusion starting with the 2020 Star Ratings (2018 YOS).

Calculating the PDC Adjustment for IP Stays and SNF Stays

The PDC modification for IP stays and SNF stays is based on two assumptions: 1) a beneficiary receives their medications through the facility during the IP or SNF stay, and 2) if a beneficiary accumulates an extra supply of their Part D medication during an IP stay or SNF stay, that supply can be used once he/she returns home. The modification is applied using the steps below:

- Identify start and end dates of relevant types of stays for beneficiaries included in adherence measures. The discharge date is included in the PDC adjustment.
  - Use IP claims from the CWF to identify IP stays, and when available for MA-PDs.
  - Use SNF claims from the CWF for PDPs, and when available for MA-PD beneficiaries, for SNF PDC adjustments. (1) Use SNF claims from the CWF with either a positive or negative paid amount with Medicare utilization days to identify Medicare Part A covered SNF stays. (2) Use SNF claims from the CWF with a condition code 04 (Beneficiary enrolled in a MA-PD) not associated with a condition code 21 and/or a no payment reason code.
  - Use IP and SNF stay encounter data when available for MA-PD beneficiaries. Additionally, if IP and SNF stay claims for MA-PD enrolled beneficiaries are reported in the CWF, the CWF will remain as an additional data source.
- Remove days of relevant stays occurring during the measurement period from the numerator and denominator of the proportion of days covered calculation.
- Shift days' supply from Part D prescription fills that overlap with the stay or subsequent fills for the same drug class to uncovered days after the end of the relevant stay, if applicable. This assumes the beneficiary receives the relevant medication from a different source during the stay and accumulates the Part D prescription fills for later use.

If SNF and IP stays cover a beneficiary's entire enrollment episode that meets the inclusion criteria, the associated proportion of member-years is not included in the rate calculation. Consequently, if SNF and IP stays span all of the beneficiary's enrollment episode(s) within the measurement period, the beneficiary is excluded from the measurement year.

The following examples provide illustrations of the implementation of these assumptions when calculating PDC.

Example 1: Gap in Coverage after IP Stay

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills on different dates of service. This beneficiary had drug coverage on days 1-8 and 12-15 and an IP stay on days 5 and 6, as illustrated in Table L-6.

Table L-6: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1	X1				X2	X2	X2	X2
Inpatient Stay					+	+									

PDC Calculation:
Covered Days: 12
Measurement Period: 15
PDC: 12/15 = 80%

With the adjustment for the IP stay, days 5 and 6 are deleted from the measurement period. Additionally, the drug coverage during the IP stay is shifted to subsequent days of no supply (in this case, days 9 and 10), based on the assumption that if a beneficiary received his/her medication through the hospital on days 5 and 6, then he/she accumulated two extra days' supply during the IP stay. The two extra days' supply is used to cover the gaps in Part D drug coverage in days 9 and 10. This is illustrated in Table L-7.

Table L-7: After Adjustment

Day	1	2	3	4	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	+	+		X2	X2	X2	X2
Inpatient Stay													

PDC Calculation:
Covered Days: 12
Measurement Period: 13
PDC: 12/13 = 92%

Example 2: Gap in Coverage before IP Stay

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills on different dates of service. This beneficiary had drug coverage from days 1-7 and 12-15, and an IP stay on days 12 and 13, as illustrated in Table L-8.

Table L-8: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1					X2	X2	X2	X2
Inpatient Stay												+	+		

PDC Calculation:
Covered Days: 11
Measurement Period: 15
PDC: 11/15 = 73%

With the adjustment for the IP stay, days 12 and 13 are deleted from the measurement period. While there are two days' supply from the IP stay on days 12 and 13, there are no days without drug coverage after the IP stay. Thus, the extra days' supply are not shifted. This is illustrated in Table L-9.

Table L-9: After Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1					X2	X2
Inpatient Stay													

PDC Calculation:
Covered Days: 9
Measurement Period: 13
PDC: 9/13 = 69%

Example 3: Gap in Coverage Before and After IP Stay

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills on different dates of service. This beneficiary had drug coverage from days 1-3, 6-9, and 12-15, and an IP stay on days 6-9, as illustrated in Table L-10.

Table L-10: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1			X2	X2	X2	X2			X3	X3	X3	X3
Inpatient Stay						+	+	+	+						

PDC Calculation:
Covered Days: 11
Measurement Period: 15
PDC: 11/15 = 73%

With the adjustment for the IP stay, days 6-9 are deleted from the measurement period. Additionally, the drug coverage during the IP stay can be applied to any days without drug coverage after the IP stay, based on the assumption that the beneficiary received his/her medication through the hospital on days 6-9. In this case, only days 10 and 11 do not have drug coverage and are after the IP stay, so two days' supply are shifted to days 10 and 11. This is illustrated in Table L-11.

Table L-11: After Adjustment

Day	1	2	3	4	5	10	11	12	13	14	15
Drug Coverage	X1	X1	X1			+	+	X2	X2	X3	X3
Inpatient Stay											

PDC Calculation:
Covered Days: 9
Measurement Period: 11
PDC: 9/11 = 82%

Example 4: Gap in Coverage After IP Stay and Overlap with Subsequent Fill of the Same Drug Class

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills on different dates of service. This beneficiary had drug coverage from days 1-4, and 7-11 for the same drug class, and an IP stay on days 2-4, as illustrated in Table L-12.

Table L-12: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1			X2	X2	X2	X2	X2				
Inpatient Stay		+	+	+											

PDC Calculation:
Covered Days: 9
Measurement Period: 15
PDC: 9/15 = 60%

With the adjustment for the IP stay, days 2-4 are deleted from the measurement period. Additionally, the drug coverage during the IP stay can be applied to any days without drug coverage after the IP stay. In the case of overlapping days with a subsequent fill of the same drug class, the days supply of the subsequent fill are shifted. In this example, the days supply of 2 to 4 during the IP stay are shifted to days 5 to 7 after the IP stay. Because day 7 includes 1 days supply of a subsequent fill (X2) of the same drug class, days 7 to 11 that corresponds to the subsequent fill are shifted to days 8 to 12. This is illustrated in Table L-13.

Table L-13: After Adjustment

Day	1	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	+	+	+	X2	X2	X2	X2	X2			
Inpatient Stay												

PDC Calculation:
Covered Days: 9
Measurement Period: 12
PDC: 9/12 = 75%

Attachment M: Methodology for Price Accuracy Measure

CMS's drug pricing performance measure evaluates the accuracy of prices displayed on Medicare Plan Finder (MPF) for beneficiaries' comparison of plan options. The accuracy score is calculated by comparing the MPF price to the prescription drug event (PDE) price and determining the magnitude and frequency of differences found when the PDE price exceeds the MPF price. This document summarizes the methods currently used to construct each contract's MPF Composite Price Accuracy Score.

Contract Selection

The Part D Star Ratings rely in part on the submission of pricing data to MPF. Therefore, only contracts with at least one plan meeting all of the following criteria are included in the analysis:

Not a PACE plan
Not a demonstration plan
Not an employer plan
Part D plan
Plan not terminated during the contract year

Only contracts with at least 30 eligible claims throughout the year are included in the accuracy measure. This ensures that the sample size of PDEs is large enough to produce a reliable accuracy score.

MPF Composite Price Accuracy Score

To calculate the MPF Composite Price Accuracy Score, the point of sale cost (ingredient costs plus dispensing fee) reported on each PDE claim is compared to the cost resulting from using the unit price reported on Plan Finder.[1] This comparison includes only PDEs for which a MPF cost can be assigned. In particular, a PDE must meet seven conditions to be included in the analysis:

1. If the NPI in the Pharmacy Cost (PC) file represents a retail only pharmacy or retail and limited access drug only pharmacy, all corresponding PDEs will be eligible for the measure. However, if the NPI in the PC file represents a retail and other pharmacy type (such as Mail, Home Infusion or Long Term Care pharmacy), only the PDE where the pharmacy service type is identified as either Community/Retail or Managed Care Organization (MCO) will be eligible. NCPDP numbers are mapped to their corresponding NPI numbers.
2. The corresponding reference NDC must appear under the relevant price ID for the pharmacy in the pricing file.[2]
3. The reference NDC must be on the plan's formulary.
4. Because the retail unit cost reported on Plan Finder is intended to apply to a 1, 2, or 3-month supply of a drugs, only claims with a Days Supply of 28-34, 60-62, or 90-93 are included. If a plan's bid indicates a 1, 2, or 3 month retail days supply amount outside of the 28-34, 60-62, or 90-93 windows, then

[1] Medicare Plan Finder unit costs are reported by plan, drug, days of supply, and pharmacy. The plan, drug, days of supply and pharmacy from the PDE are used to assign the corresponding Medicare Plan Finder unit cost posted on medicare.gov on the date of the PDE.

[2] Medicare Plan Finder prices are reported at the reference NDC level. A reference NDC is a representative NDC of drugs with the same brand name, generic name, strength, and dosage form. To map NDCs on PDEs to a reference NDC, we use First Data Bank (FDB) and Medi-Span to create an expanded list of NDCs for each reference NDC, consisting of NDCs with the same brand name, generic name, strength, and dosage form as the reference NDC. This expanded NDC list allows us to map PDE NDCs to MPF reference NDCs.

additional days supply values may be included in the accuracy measure for the plan. For example, a plan that submits a 3 month retail supply of 100 days in their bid will have claims with a days supply of 90-100 included in their accuracy measure calculation.

5. PDEs for dates of service during which the plan was suppressed from Plan Finder or where the relevant pharmacy or drug was not reported in Plan Finder are not included since no Plan Finder cost can be assigned.[3]
6. PDEs for compound drugs or non-covered drugs are not included.
7. The PDE must occur in Quarter 1 through 3 of the year. Quarter 4 PDEs are not included because MPF prices are not updated during this last quarter.

The MPF Composite Price Accuracy Measure factors in both how much and how often PDE prices exceeded the prices reflected on the MPF. The contract's MPF Composite Price Accuracy score is the average of the Price Accuracy Score, which measures the difference between PDE total cost and MPF total cost,[4] and the Claim Percentage Score, which measures the share of claims where PDE prices are less than or equal to MPF prices.

Once MPF unit ingredient costs are assigned, the MPF ingredient cost is calculated by multiplying the unit costs reported on MPF by the quantity listed on the PDE. The PDE total cost (TC) is the sum of the PDE ingredient cost paid and the PDE dispensing fee. Likewise, the MPF TC is the sum of the MPF ingredient cost and the MPF dispensing fee that corresponds to the same pharmacy, plan, and days of supply as that observed in the PDE. Each claim is then given a score based on the difference between the PDE TC and the MPF TC. If the PDE TC is lower than or equal to the MPF TC, the claim receives a score equal to zero. In other words, contracts are not penalized when point of sale costs are lower than or equal to the advertised costs. However, if the PDE TC is higher than the MPF TC, then the claim receives a score equal to the difference between the PDE TC and the MPF TC.[5] [6] The contract level MPF Price Accuracy Index is the sum of the claim level scores and PDE TC across all PDEs that meet the inclusion criteria, divided by the PDE TC for those same claims. The MPF Claim Percentage Index is the percent of all PDEs that meet the inclusion criteria with a PDE TC higher than the MPF TC. Note that the best possible MPF Price Accuracy Index is 1, and the best possible MPF Claim Percentage Index is 0. This occurs when the MPF TC is never lower than the PDE TC. The formulas below illustrate the calculation of the contract level MPF Price Accuracy Index and MPF Claim Percentage Index:

$$\text{Price Accuracy Index} = \frac{\sum_i \max(TC_{iPDE} - TC_{iPF}, 0) + \sum_i TC_{iPDE}}{\sum_i TC_{iPDE}}$$

where

[3] Because CMS continues to display pharmacy and drug pricing data for sanctioned plans on MPF to their current enrollees, sanctioned plans are not excluded from this measure. If, however, CMS completely suppresses a sanctioned contract's data from MPF display, then they would be excluded from the measure.

[4] MPF total costs are rounded to the nearest cent. For example, if the MPF total cost is $10.237, then it is rounded to $10.24. MPF unit costs are not rounded.

[5] To account for potential rounding errors, this analysis requires that the PDE cost exceed the rounded MPF cost by at least a two cent ($0.02) in order to be counted towards the accuracy score. For example, if the PDE cost is $10.25 and the rounded MPF cost is $10.23, the 2-cent difference would be counted towards plan's accuracy score. However, if the rounded MPF cost is higher than $10.23, the difference would not count towards the plan's accuracy score.

[6] The MPF data includes floor pricing. For plan-pharmacy drugs with a floor price, if the MPF price is lower than the floor price, the PDE price is compared against the floor price.

TC_{iPDE} is the ingredient cost plus dispensing fee reported in PDE_i and TC_{iMPF} is the ingredient cost plus dispensing fee calculated from MPF data, based on the PDE_i reported NDC, days of supply, and pharmacy, then rounded to the nearest cent.

$$\text{Claim Percentage Index} = \frac{\sum_i \text{Claims}_{i\text{PDE}>\text{PF}}}{\sum_i \text{Claims}_{i\text{Total}}}$$

where

$\text{Claims}_{i\text{PDE}>\text{PF}}$ is the total number of claims where the PDE price is greater than the rounded MPF price

$\text{Claims}_{i\text{Total}}$ is the total number of claims

We use the following formulas to convert the Claim Percentage Index and Price Accuracy Index into the MPF.

Composite Price Accuracy score:

$$\text{Price Accuracy Score} = 100 - [(\text{Price Accuracy Index} - 1) \times 100]$$

$$\text{Claim Percentage Score} = (1 - \text{Claim Percentage Index}) \times 100$$

$$\text{MPF Composite Price Accuracy Score} = (0.5 \times \text{Price Accuracy Score}) + (0.5 \times \text{Claim Percentage Score})$$

The MPF Composite Price Accuracy Score is rounded to the nearest whole number.

Example of Accuracy Index Calculation

Table M-1 shows an example of the MPF Composite Price Accuracy Score calculation. This contract has 4 claims, for 4 different NDCs and 4 different pharmacies. This is an abbreviated example for illustrative purposes only; in the actual accuracy index, a contract must have 30 eligible claims to be evaluated.

From each of the 4 claims, the PDE ingredient cost, dispensing fee, and quantity dispensed are obtained. Additionally, the plan ID, days of supply, date of service, and pharmacy number are collected from each PDE to identify the MPF data that had been submitted by the contract and posted on Medicare.gov on the PDE dates of service. The NDC on the claim is first assigned the appropriate reference NDC, based on the brand name, generic name, strength, and dosage form. Using the reference NDC, the following MPF data are obtained: brand/generic dispensing fee (as assigned by the pharmacy cost file) and unit cost (as assigned by the Price File corresponding to that pharmacy and days of supply on the date of service). The PDE cost is the sum of the PDE ingredient cost and dispensing fee. The MPF cost is computed as the quantity dispensed from PDE multiplied by the MPF unit cost plus the MPF brand/generic dispensing fee (brand or generic status is assigned based on the NDC), and then rounded to the nearest cent. The last column shows the amount by which the PDE cost is higher than the rounded MPF cost. When PDE cost is less than or equal to the rounded MPF cost, this value is zero. The Price Accuracy Index is the sum of the last column plus the sum of PDE costs all divided by the sum of PDE costs. The Claim Percentage Index is the number of rows where the last column is greater than zero divided by the total number of rows.

Table M-1: Example of Price Accuracy Index Calculation

NDC	Pharmacy Number	PDE Data DOS	PDE Data Ingredient Cost	PDE Data Dispensing Fee	PDE Data Quantity Dispensed	PDE Days of Supply	MPF Data Biweekly Posting Period	MPF Data Unit Cost	MPF Data Dispensing Fee Brand	MPF Data Dispensing Fee Generic	Calculated Value Brand or Generic Status	Calculated Value Total Cost PDE	Calculated Value Total Cost MPF	Calculated Value Amount that PDE is higher than MPF
A	111	01/08/2022	3.82	2	60	60	01/06/22 - 01/19/22	0.014	2.25	2.75	B	5.82	3.09	2.73
B	222	01/24/2022	0.98	2	30	60	01/20/22 - 02/02/22	0.83	1.75	2.5	G	2.98	27.40	0
C	333	02/11/2022	10.48	1.5	24	28	02/03/22 - 02/16/22	0.483	2.5	2.5	B	11.98	14.09	0
D	444	02/21/2022	47	1.5	90	30	02/17/22 - 03/01/22	0.48	1.5	2.25	G	48.50	45.45	3.05
											Totals	69.28		5.78
											Price Accuracy Index			1.08343
											Claim Percentage Index			0.5
											MPF Composite Price Accuracy Score			71

PDE = Prescription Drug Event
MPF = Medicare Plan Finder

Attachment N: MTM CMR Completion Rate Measure Scoring Methodologies

Medicare Part D Reporting Requirements Measure (D11: MTM CMR Completion Rate Measure)

Step 1: Start with all contracts that enrolled beneficiaries in MTM at any point during contract year 2022. Beneficiaries with multiple records that contain varying information for the same contract are excluded from the measure calculation for that contract.

Step 2: Exclude contracts that did not enroll 31 or more beneficiaries in their MTM program who met the measure denominator criteria during contract year 2022.
Next, exclude contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2023), or that were not required to participate in data validation.
Additionally, exclude contracts that did not score at least 95% on data validation for their plan reporting of the MTM Program section and contracts that scored 95% or higher on data validation for the MTM Program section but that were not compliant with data validation standards/sub-standards for at least one of the following MTM data elements. We define a contract as being non-complaint if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation.

- MBI Number (Element B)
- Date of MTM program enrollment (Element H)
- Met the specified targeting criteria per CMS – Part D requirements (Element I)
- Date met the specified targeting criteria per CMS – Part D requirements (Element J)
- Date of MTM program opt-out, if applicable (Element K)
- Received annual CMR with written summary in CMS standardized format (Element O)
- Date(s) of CMR(s) (Element P)

Step 3: After removing contracts' and beneficiaries' data excluded above, suppress contract rates based on the following rules:

File DV failure: Contracts that failed to submit the CY 2022 MTM Program Reporting Requirements data file or who had a missing DV score for MTM are listed as "CMS identified issues with this plan's data."

Section-level DV failure: Contracts that score less than 95% in DV for their CY 2022 MTM Program Reporting Requirements data are listed as "CMS identified issues with this plan's data."

Element-level DV failure: Contracts that score 95% or higher in DV for their CY 2022 MTM Program Reporting Requirements data but that failed at least one of the seven data elements are listed as "CMS identified issues with this plan's data."

Small size: Contracts that have not yet been suppressed and have fewer than 31 beneficiaries enrolled are listed as "Not enough data available."

Organizations can view their own plan reporting data validation results in HPMS (https://hpms.cms.gov/). From the home page, select Monitoring | Plan Reporting Data Validation.

Step 4: Calculate the rate for the remaining contracts using the following formula:
Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period / Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period, met the specified targeting criteria per CMS during the reporting period, weren't in hospice at any point during the reporting period, and

who were enrolled in the MTM program for at least 60 days during the reporting period. Beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time in the measurement year are included in the denominator and the numerator if they received a CMR within this timeframe. Beneficiaries are excluded from the measure calculation if they were enrolled in the contract's MTM program for less than 60 days and did not receive a CMR within this timeframe.

Attachment O: Methodology for the Puerto Rico Model

Puerto Rico has a unique health care market with a large percentage of low-income individuals in both Medicare and Medicaid and a complex legal history that affects the health care system in many ways. Puerto Rican beneficiaries are not eligible for LIS. The categorization of contracts into final adjustment categories for the Categorical Adjustment Index (CAI) relies on both the use of a contract's percentages of beneficiaries with Low Income Subsidy/Dual Eligible (LIS/DE) and disabled beneficiaries. Since the percentage of LIS/DE is a critical element in the categorization of contracts to identify the contract's CAI, an additional adjustment is done for contracts that solely serve the population of beneficiaries in Puerto Rico to address the lack of LIS. The additional analysis for the adjustment results in a modified percentage of LIS/DE beneficiaries that is subsequently used to categorize the contract in its final adjustment category for the CAI.
The contract-level modified LIS/DE percentages for Puerto Rico contracts for the 2024 Star Ratings are developed using the following sources of information:

- The 2021 1-year American Community Survey (ACS) estimates for the percentage of people living below the Federal Poverty Level (FPL).
- The 2021 ACS 5-year estimates for the percentage of people living below 150% of the FPL; for Puerto Rico and for the 10 poorest US states (which may include the District of Columbia).
- The Medicare enrollment data file for those enrolled during 2022 provided for beneficiaries who were alive at least through December 2022, the percentage of each contract's beneficiaries who were DE, and for non-Puerto Rico contracts, the percentage who were LIS/DE. Beneficiary DE status was determined using a) the monthly beneficiary dual status codes, b) identification of Low Income Part D enrollees who reside in the US Territories, and c) beneficiaries with Medicaid coverage/who are Medicaid eligible by the Point of Sale contractor. For non-Puerto Rico contracts, beneficiaries who were LIS were determined using the monthly beneficiary LIS status codes, and beneficiaries were classified LIS/DE by combining the beneficiaries identified as DE and beneficiaries identified as LIS.

The following steps are employed to determine the modified percentages of LIS/DE for MA contracts solely serving the population of beneficiaries in Puerto Rico. All references to contracts in Puerto Rico are limited to the contracts solely serving the population of beneficiaries in Puerto Rico.

- The 10 states with the highest proportion of people living below the FPL are identified, based on 2021 1-year data from ACS (https://www.census.gov/content/dam/Census/library/publications/2022/acs/acsbr22-014.pdf, see Table 1). *The states identified are: Alabama, Arkansas, District of Columbia, Kentucky, Louisiana, Mississippi, New Mexico, Oklahoma, South Carolina, and West Virginia.*
- Data are aggregated from Medicare Advantage contracts that had at least 90% of their beneficiaries enrolled with mailing addresses within the 10 highest poverty states identified in step (1).
  For the 2024 Star Ratings adjustment, the data used for the model development included a total of 92 Medicare Advantage contracts with at least 90% of their beneficiaries with mailing addresses in one of the ten poorest states listed above.
- A linear regression model is developed using the known LIS/DE percentage and the corresponding DE percentage from the MA contracts in the 10 highest poverty states with at least 90% of their beneficiaries with mailing addresses in one of the ten states.
- The model for Puerto Rico is developed using the model in step (3) as its base.

  The estimated slope from the linear fit in the previous step (3) is retained to approximate the expected relationship between LIS/DE for each contract in Puerto Rico and its DE percentage. However, as Puerto Rico contracts are expected to have a larger percentage of low-income beneficiaries, the intercept term is adjusted to be more suitable for use with Puerto Rico contracts as follows:

  The intercept term for the Puerto Rico model is estimated by assuming that the Puerto Rico model will pass

through the point (x, y) where x is the observed average DE percentage in the Puerto Rico contracts, and y is the expected average percentage of LIS/DE in Puerto Rico. The expected average percentage of LIS/DE in Puerto Rico (the y value) is not observable but is estimated by multiplying the observed average percentage of LIS/DE in the 10 highest poverty states identified in step (1) by the ratio based on the 2021 5-year ACS estimates of the percentage living below 150% of the FPL in Puerto Rico compared to the corresponding percentage in the 10 poorest US states.

- To obtain each Puerto Rico contract's modified LIS/DE percentage, a contract's observed DE percentage is used in the Puerto Rico model developed in the previous step (4).

  A contract's observed DE percentage is multiplied by the slope estimate, and then, the newly derived intercept term is added to the product. The estimated modified LIS/DE percentage is capped at 100%. Any estimated LIS/DE percentage that exceeds 100% is categorized in the final adjustment category for LIS/DE with an upper bound of 100%.

  Note that the District of Columbia is included with the 50 US states when determining the 10 poorest in 2021. All estimated modified LIS/DE values for Puerto Rico are rounded to six decimal places when expressed as a percentage. (This rounding rule aligns with the limits for the adjustment categories for LIS/DE for the CAI.)

Model

The generic model developed to estimate a contract's LIS/DE percentage using its DE percentage is as follows:

$$\widehat{\text{LIS/DE}} = (\text{Slope} \times \text{contract's DE percentage}) + (\text{intercept})$$

Using the data from the 10 highest poverty states, the estimated slope was calculated to be 0.930021.

$$\widehat{\text{LIS/DE}} = (0.930021 \times \text{contract's DE percentage}) + (\text{intercept})$$

Next, the intercept for the Puerto Rico model was determined using the point (x, y) where x is the observed average DE percentage in Puerto Rico contracts (29.200398%) and y is an estimated expected average percentage of LIS/DE in Puerto Rico.

To calculate the estimated expected average percentage of LIS/DE in Puerto Rico, the observed average percentage of LIS/DE in the 10 poorest US states identified in step (1) is multiplied by the ratio of the percentage of Puerto Rico residents living below 150% of the FPL to the analogous percentage in the 10 poorest US states.

Description	Value
Percent of PR residents below 150% of FPL	59.500000%
Percent of residents in the 10 poorest US states below 150% of FPL	26.539801%
Observed average LIS/DE percentage in the 10 poorest US states	39.159485%
Observed average DE percentage in Puerto Rico contracts	29.200398%

The product thus becomes $\left(39.159485 \times \frac{59.500000}{26.539801}\right)$.

The new intercept for the Puerto Rico model is as follows:

$$\text{new intercept} = \left(39.159485 \times \frac{59.500000}{26.539801}\right) - (0.930021 \times 29.200398)$$

The final model to estimate the percentage of LIS/DE in Puerto Rico model is as follows:

$$\widehat{\text{LIS/DE}} = (0.930021 \times \text{contract's DE percentage}) + \left(39.159485 \times \frac{59.500000}{26.539801}\right) - (0.930021 \times 29.200398)$$

Example

To calculate the contract-level modified LIS/DE percentage for a hypothetical contract from Puerto Rico with an observed DE percentage of 25%, the value of 25.000000% is used in the model developed.

$$\widehat{\text{LIS/DE}} = (0.930021 \times \text{contract's DE percentage}) + \left(39.159485 \times \frac{59.500000}{26.539801}\right) - (0.930021 \times 29.200398)$$

The contracts percentage of 25.000000% is substituted into the Puerto Rico model.

$$\widehat{\text{LIS/DE}} = (0.930021 \times 25.000000) + \left(39.159485 \times \frac{59.500000}{26.539801}\right) - (0.930021 \times 29.200398)$$

The contract-level modified LIS/DE percentage for a hypothetical Puerto Rico contract that has an observed DE percentage of 25.000000% is 83.885811%.

The final adjustment category for the CAI adjustment is identified using the DE percentage of 25.000000% and the LIS/DE percentage 83.885811%.

Attachment P: Identification of Contracts Affected by Disasters

Natural disasters such as hurricanes and wildfires can directly affect Medicare beneficiaries and providers, as well as the Parts C and D organizations that provide them with important medical care and prescription drug coverage. These disasters may negatively affect the underlying operational and clinical systems that CMS relies on for accurate performance measurement in the Star Ratings program.

The 2024 Rate Announcement (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html) describes CMS's policy for making adjustments in the Star Ratings to take into account the effects of extreme and uncontrollable circumstances which occurred during the performance period. This is also codified in regulation at §422.166(i) and §423.186(i).

Operational Steps to Calculating Enrollment Impacted in Affected Contracts.

- Identify the areas which experienced both extreme and uncontrollable circumstances as defined in Section 1135 (g) of the Act and also are within a county or statistically equivalent entity, U.S. territory or tribal government designated in a major disaster declaration under the Stafford Act.
  - Areas where the Health and Human Services (HHS) Secretary exercised their authority under Section 1135 of the Act can be found at the Public Health Emergency website at https://www.phe.gov/emergency/news/healthactions/section1135/Pages/default.aspx
  - Major disaster areas are identified by the Federal Emergency Management Agency (FEMA) website at: https://www.fema.gov/disasters.

  Table P-1 lists the Section 1135 waivers issued by the HHS Secretary along with associated FEMA major disaster information that falls within the performance period for the 2024 Star Ratings.

Table P-1: Section 1135 waivers issued in relation to the FEMA major disaster declarations

Section 1135 Waiver Date Issued	Waiver or Modification of Requirements Under Section 1135 of the Social Security Act	FEMA Incident Type	Affected State	Incident Start Date
5/9/2022	New Mexico Wildfires and Straight-line Winds	Wildfires	New Mexico	4/5/2022
8/2/2022	Kentucky Severe Storms, Flooding, Landslides, and Mudslides	Severe Storms, Flooding, Landslides, and Mudslides	Kentucky	7/26/2022
9/20/2022	Tropical Storm/Hurricane Fiona	Hurricane	Puerto Rico	9/17/2022
9/26/2022	Hurricane Ian	Hurricane	Florida	9/23/2022
9/30/2022	Hurricane Ian	Hurricane	South Carolina	9/25/2022

- Identify the counties or statistically equivalent entities which were declared as Individual Assistance areas by each of the FEMA major disaster declarations that meet the criteria set out in Step 1 below.

Table P-2 lists all of the relevant FEMA major disaster declarations along with the state and associated Individual Assistance counties.

Table P-2: Individual Assistance counties in FEMA Major Disaster Declared States

FEMA Declaration	State	FEMA Individual Assistance Counties or County-Equivalents
DR-4652- NM	New Mexico	Colfax, Lincoln, Mora, San Miguel, Valencia
DR-4663-KY	Kentucky	Breathitt, Clay, Floyd, Knott, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley
DR-4671-PR	Puerto Rico	Adjuntas, Aguada, Aguadilla, Aguas Buenas, Aibonito, Anasco, Arecibo, Arroyo, Barceloneta, Barranquitas, Bayamon, Cabo Rojo, Caguas, Camuy, Canovanas, Carolina, Catano, Cayey, Ceiba, Ciales, Cidra, Coamo, Comerio, Corozal, Culebra, Dorado, Fajardo, Florida, Guanica, Guayama, Guayanilla, Guaynabo, Gurabo, Hatillo, Hormigueros, Humacao, Isabela, Jayuya, Juana Diaz, Juncos, Lajas, Lares, Las Marias, Las Piedras, Loiza, Luquillo, Manati, Maricao, Maunabo, Mayaguez, Moca, Morovis, Naguabo, Naranjito, Orocovis, Patillas, Penuelas, Ponce, Quebradillas, Rincon, Rio Grande, Sabana Grande, Salinas, San German, San Juan, San Lorenzo, San Sebastian, Santa Isabel, Toa Alta, Toa Baja, Trujillo Alto, Utuado, Vega Alta, Vega Baja, Vieques, Villalba, Yabucoa, Yauco
DR-4673-FL	Florida	Brevard, Charlotte, Collier, DeSoto, Flagler, Glades, Hardee, Hendry, Highlands, Hillsborough, Lake, Lee, Manatee, Monroe, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Sarasota, Seminole, St. Johns, Volusia
DR-4677-SC	South Carolina	Charleston, Georgetown, Horry

- Identify the service area at the state/county level for each contract in operation during the performance period. The service area of some organization types rated in the Star Ratings are not defined at the state/county level, so their service area must be transformed to include all states and counties covered by their service area.

Table P-3 lists how the service area for each organization type rated in the Star Ratings is defined and what transformation, if any, is needed to create a common state/county level file for all contracts.

Table P-3: Organization type service areas and necessary transformations

Star Rating Organization Types	How Service Area is defined	How Service Area is transformed
1876 Cost, E-CCP, E-PDP, E-PFFS, Local CCP, MSA, PFFS, R-PFFS & R-CCP	State/County	Not necessary, service area is defined at the state/county level
Regional CCP	MA Region	A record is created for each state/county within the MA region
PDP	PDP Region	A record is created for each state/county within the PDP region

- Compare the Individual Assistance states and counties from Step 2 below to the service area from all contracts created in Step 3 below with the state and counties. Create a list of all contracts which have any county that matches in both lists.
- Create a second list of all contracts that do not share any service area with the Individual Assistance counties, so that information on the status of all contracts is accounted for during the performance period.
- Identify the timeframe for each disaster and the associated enrollment files. Each of the disasters occurred during a specific period of time. Since the enrollment in a contract is constantly changing, CMS used the enrollment the contract was paid for in a month that as closely matched the disaster period in the specific state/county as possible for all further processing, following the months in the table below.

Table P-4 shows each of the disasters where relief was granted along with the disaster start date, and the enrollment file month that was used for that specific disaster. The enrollment file choice was based on the enrollment file cut-off date the file was created.

Table P-4: Major Disasters with associated enrollment months

FEMA Declaration	State	Start Date	Enroll File	Enroll Cut Off
DR-4652-NM	New Mexico	4/5/2022	May 2022	April 8, 2022
DR-4663-KY	Kentucky	7/26/2022	September 2022	August 5, 2022
DR-4671-PR	Puerto Rico	9/17/2022	October 2022	September 9, 2022
DR-4673-FL	Florida	9/23/2022	November 2022	October 7, 2022
DR-4677-SC	South Carolina	9/25/2022	November 2022	October 7, 2022

- Calculate disaster impacted enrollment for contracts experiencing multiple disasters. Because the contracts serve areas of different sizes and can sometimes serve large, diverse areas, it is common for a contract to be affected by more than one of the disasters. To account for this, CMS averaged the county/state level enrollments from each of corresponding enrollment periods in which the contract was affected.

Table P-5 shows an example where all possible enrollment periods are accounted for and how the enrollment for a contract in a state/county which matched the contract's service area state/county was calculated. Enrollment in out of service area state/counties was not included.

Table P-5: How enrollment periods were combined for contracts experiencing multiple disasters

Formula ID	Enrolled 202X_10	Enrolled 202X_11	Enrolled 202X_12	Enrollment Used
B	True	True	True	(202X_10 + 202X_11 + 202X_12) / 3
C	True	True		(202X_10 + 202X_11) / 2
F	True		True	(202X_10 + 202X_12) / 2
H	True			202X_10
J		True	True	(202X_11 + 202X_12) / 2
L		True		202X_11
N			True	202X_12
P				0 (zero)

- Using the enrollment for the contract developed in Step 7 below, take the sum of the enrollment in the entire service area for the contract to be used in further processing.
- Using the enrollment for the contract developed in Step 7 below, take the sum of the enrollment in all of the Individual Assistance counties that correspond to the contract service area.
- Using the final list of affected contracts from Step 4 below, calculate the percentage of the contract's total service area enrollment that was affected by the Individual Assistance area enrollment. Create flags for the ≥25% and ≥60% thresholds for processing of the ratings data for those contracts.

Example:

Steps 1 and 2 use the disasters and counties that have already been defined in Tables P-1 & P-2. For Steps 3 through 10, we use an example contract, HAAAA, which offers services to some counties from both California and Texas.

Step 3, Table P-6 below contains the full list of counties that make up the service area for contract HAAAA.

Step 4, the Individual Assistance County column is included in Table P-6. Rows marked TRUE are matches from Individual Assistance counties in the disasters for year 202X and the service areas of HAAAA. The rows marked FALSE were not Individual Assistance counties for any of the disasters in HAAAA.

Step 5, since the example contract HAAAA has service areas that coincide with disaster counties, it is not included in the list of contracts not affected.

Step 6, there are two separate enrollment periods associated with the disasters that match example contract HAAAA's service area. Those enrollment periods are 202X/09 & 202X/11. Columns for all enrollment periods are included in Table P-6, but only the valid enrollment periods contain the necessary data.

Step 7, the average enrollment is calculated for the included enrollment periods. The result of each average enrollment calculation for each county in the example contract's service area is shown in the final column of Table P-6.

Table P-6: Example Contract HAAAA's Service Areas and Enrollment during Relevant Disasters

FIPS Code	County Name	ST CD	EGHP County	Individual Assistance County	Enrolled 202X/09	Enrolled 202X/10	Enrolled 202X/11	Average Enrollment
06003	Alpine	CA	No	FALSE	8	-	8	8
06009	Calaveras	CA	No	FALSE	849	-	850	850
06011	Colusa	CA	No	FALSE	168	-	166	167
06015	Del Norte	CA	No	FALSE	369	-	360	364
06023	Humboldt	CA	No	FALSE	702	-	710	706
06045	Mendocino	CA	No	TRUE	428	-	429	428
06049	Modoc	CA	No	FALSE	157	-	158	158
06063	Plumas	CA	No	FALSE	182	-	181	182
06093	Siskiyou	CA	No	FALSE	798	-	800	799
06105	Trinity	CA	No	FALSE	150	-	150	150
48043	Brewster	TX	Yes	FALSE	16	-	15	16
48047	Brooks	TX	Yes	FALSE	28	-	27	28
48049	Brown	TX	Yes	FALSE	64	-	65	64
48057	Calhoun	TX	Yes	TRUE	28	-	28	28
48093	Comanche	TX	Yes	FALSE	33	-	32	32
48103	Crane	TX	Yes	FALSE	8	-	8	8
48109	Culberson	TX	Yes	FALSE	3	-	3	3
48123	DeWitt	TX	Yes	TRUE	26	-	26	26
48131	Duval	TX	Yes	FALSE	30	-	28	29
48133	Eastland	TX	Yes	FALSE	64	-	62	63
48143	Erath	TX	Yes	FALSE	61	-	59	60

FIPS Code	County Name	ST CD	EGHP County	Individual Assistance County	Enrolled 202X/09	Enrolled 202X/10	Enrolled 202X/11	Average Enrollment
48163	Frio	TX	Yes	FALSE	43	-	42	42
48171	Gillespie	TX	Yes	FALSE	17	-	17	17
48175	Goliad	TX	Yes	TRUE	18	-	18	18
48177	Gonzales	TX	Yes	TRUE	41	-	41	41
48237	Jack	TX	Yes	FALSE	35	-	34	34
48239	Jackson	TX	Yes	TRUE	30	-	30	30
48255	Karnes	TX	Yes	TRUE	19	-	19	19
48265	Kerr	TX	Yes	FALSE	85	-	86	86
48283	La Salle	TX	Yes	FALSE	25	-	25	25
48297	Live Oak	TX	Yes	FALSE	24	-	24	24
48301	Loving	TX	Yes	FALSE	0	-	0	0
48311	McMullen	TX	Yes	FALSE	4	-	4	4
48321	Matagorda	TX	Yes	TRUE	144	-	140	142
48323	Maverick	TX	Yes	FALSE	160	-	156	158
48371	Pecos	TX	Yes	FALSE	20	-	21	20
48377	Presidio	TX	Yes	FALSE	50	-	49	50
48389	Reeves	TX	Yes	FALSE	8	-	8	8
48391	Refugio	TX	Yes	TRUE	21	-	21	21
48443	Terrell	TX	Yes	FALSE	9	-	9	9
48463	Uvalde	TX	Yes	FALSE	13	-	10	12
48469	Victoria	TX	Yes	TRUE	158	-	154	156
48475	Ward	TX	Yes	FALSE	15	-	15	15
48495	Winkler	TX	Yes	FALSE	20	-	20	20

Step 8, sum the average enrollment from all rows from Table P-6. The total comes out to 5,120 for contract HAAAA.

Step 9, sum the average enrollment from all the rows from Table P-6 where the Individual Assistance counties is TRUE for contract HAAAA. The Individual Assistance total comes out to 909.

Step 10, calculate the final percentage for contract HAAAA. (909 / 5,120) * 100 = 17.753906 = 18%. Both flags for >=25% and >=60% are set to false since the example contract did not meet those thresholds.

Attachment Q: Missing Data Messages

CMS uses a standard set of messages in the Star Ratings when there are no numeric data available for a contract. This attachment provides the rules for assignment of those messages in each level of the Star Ratings.

Measure level messages

Table Q-1 contains all of the possible messages that could be assigned to missing data at the measure level.

Table Q-1: Measure level missing data messages

Message	Measure Level
Coming Soon	Used for all measures in MPF between Oct 1 and when the actual Star Rating data go live
Medicare shows only a Star Rating for this topic	Used in the numeric data for the Part C & D improvement measures in MPF and Plan Preview 2
Not enough data available	There were data for the contract, but not enough to pass the measure exclusion rules
CMS identified issues with this plan's data	Data were materially biased, erroneous and/or not reported by a contract required to report
Not Applicable	Used in the numeric data for the improvement measures in Plan Preview 1. In the HPMS Measure Star Page when a measure does not apply for a contract. When a Disenrollment Reasons Survey measure does not apply to the contract type.
Benefit not offered by plan	The contract was required to report this HEDIS measure but doesn't offer the benefit to members
Plan too new to be measured	The contract is too new to have submitted measure data
No data available	There were no data for the contract included in the source data for the measure
Plan too small to be measured	The contract had data but did not have enough enrollment to pass the measure exclusion rules
Plan not required to report measure	The contract was not required to report the measure

Assignment rules for Part C measure messages

Part C uses a set of rules for assigning the missing data message that varies by the data source. The rules for each data source are defined below.

Appeals (IRE) measures (C28 & C29):

Has CMS identified issues with the contract's data?
- Yes: Display message: CMS identified issues with this plan's data
- No: Is there a valid numeric measure rate?
  - Yes: Display the numeric measure rate
  - No: Is the contract effective date > 01/01/2022?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

CAHPS measures (C03, C19, C20, C21, C22, C23, & C24):

Is there a valid numeric CAHPS measure rate?
- Yes: Display the numeric CAHPS measure rate
- No: Is the contract effective date > 07/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Is the CAHPS measure rate NR?
    - Yes: Display message: Not enough data available
    - No: Is the CAHPS measure rate NA?
      - Yes: Display message: No data available
      - No: Display message: Plan too small to be measured

Call Center – Foreign Language Interpreter and TTY Availability measure (C30):

Is there a valid call center numeric rate?
- Yes: Display the call center numeric rate
- No: Is the organization type 1876 Cost, MSA, or Employer/Union Only Direct Contract PDP?
  - Yes: Display message: Plan not required to report measure
  - No: Is the contract effective date > 01/01/2023?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (C25):

Is the contract effective date > 01/01/2022?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2022?
  - Yes: Display message: Not enough data available
  - No: Is there a valid numeric CTM rate?
    - Yes: Display the numeric CTM rate
    - No: Display message: No data available

HEDIS measures except PCR and TRC (C01, C02, C08 – C11, C14, C16, C18):

Was the contract required to report HEDIS?
- Yes: Was the contract enrollment < 500 in July 2022?
  - Yes: Display message: Plan too small to be measured
  - No: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Was a valid patient level detail file 1 submitted and the measure data usable?
      - Yes: Is the status NA?
        - Yes: Display message: Not enough data available
        - No: Was contract enrollment at least 500 but less than 1,000?
          - Yes: Is the measure reliability at least 0.7?
            - Yes: Display the HEDIS measure numeric rate
            - No: Display message: No data available
          - No: Display the HEDIS measure numeric rate
      - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS PCR 18 and older (C15)

Was the contract required to report HEDIS?
- Yes: Was the contract enrollment < 500 in July 2022?
  - Yes: Display message: Plan too small to be measured
  - No: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Was a valid patient level detail file 1 submitted and the measure data usable?
      - Yes: Is the combined denominator for the 18-64 and 65+ measures <150?
        - Yes: Display message: Not enough data available
        - No: Was contract enrollment at least 500 but less than 1,000?
          - Yes: Is the measure reliability at least 0.7?
            - Yes: Display the HEDIS measure numeric rate
            - No: Display message: No data available
          - No: Display the HEDIS measure numeric rate
      - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS TRC average (C17):

Was the contract required to report HEDIS?
- Yes: Was the contract enrollment < 500 in July 2022?
  - Yes: Display message: Plan too small to be measured
  - No: Is the audit designation for all four TRC measures R?
    - No: Is the audit designation for any of the four TRC measures BD, BR, or NR?
      - Yes: Display message: CMS identified issues with this plan's data
      - No: Is the audit designation for any of the four TRC measures NB?
        - Yes: Display message: Benefit not offered by plan
        - No: The audit designation for one of the four TRC measures is NQ.
          Display message: Plan not required to report measure
    - Yes: Was a valid patient level detail file 1 submitted and the measure data usable?
      - Yes: Is the status for any component of the TRC average measure NA?
        - Yes: Display message: Not enough data available
        - No: Was contract enrollment at least 500 but less than 1,000?
          - Yes: Is the measure reliability at least 0.7?
            - Yes: Display the HEDIS measure numeric rate
            - No: Display message: No data available
          - No: Display the HEDIS measure numeric rate
      - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS SNP measures (C06 & C07):

Is the organization type (1876 Cost, PFFS, MSA) or is SNP not offered in 2024?
- Yes: Display message: Plan not required to report measure
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Is there a valid HEDIS measure numeric rate?
      - Yes: What is the status?
        - NA: Display message: Not enough data available
        - R: Display the HEDIS measure numeric rate
      - No: Display message: No data available

HEDIS-HOS measures (C04, C12, & C13):

Is there a valid HEDIS-HOS numeric rate?
- Yes: Display the HEDIS-HOS numeric rate
- No: Is the contract effective date > 01/01/2021?
  - Yes: Display message: Plan too new to be measured
  - No: Is the February 2022 contract enrollment < 500?
    - Yes: Display message: Plan too small to be measured
    - No: Is there a HEDIS-HOS rate code?
      - Yes: Assign message according to value below:
        - NA: Display message: Not enough data available
        - NB: Display message: Benefit not offered by plan
      - No: Display message: No data available

Members Choosing to Leave the Plan (C26):

Is there a valid numeric voluntary disenrollment rate?
- Yes: Display the numeric voluntary disenrollment rate
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Plan Reporting SNP measure (C05):

Is the organization type (1876 Cost, PFFS, MSA) or is SNP not offered in 2024?
- Yes: Display message: Plan not required to report measure
- No: Is there a valid Plan Reporting numeric rate?
  - Yes: Display the Plan Reporting numeric rate
  - No: Were there Data Issues Found?
    - Yes: Display message: CMS identified issues with this plan's data
    - No: Is the contract effective date > 01/01/2022?
      - Yes: Display message: Plan too new to be measured
      - No: Display message: No data available

Improvement (Star Ratings) measure (C27):

Is there a valid improvement measure rate?
- Yes: Display message: Medicare shows only a Star Rating for this topic
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Assignment rules for Part D measure messages

CAHPS measures (D05, D06):

Is there a valid numeric CAHPS measure rate?
- Yes: Display the numeric CAHPS measure rate
- No: Is the contract effective date > 07/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Is the CAHPS measure rate NR?
    - Yes: Display message: Not enough data available
    - No: Is the CAHPS measure rate NA?
      - Yes: Display message: No data available
      - No: Display message: Plan too small to be measured

Call Center – Foreign Language Interpreter and TTY Availability measure (D01):

Is there a valid call center numeric rate?
- Yes: Display the call center numeric rate
- No: Is the organization type 1876 Cost?
  - Yes: Display message: Plan not required to report measure
  - No: Is the contract effective date > 01/01/2023?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (D02):

Is the contract effective date > 01/01/2022?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2022?
  - Yes: Display message: Not enough data available
  - No: Is there a valid numeric CTM rate?
    - Yes: Display the numeric CTM rate
    - No: Display message: No data available

Improvement (Star Ratings) measure (D04):

Is there a valid improvement measure rate?
- Yes: Display message: Medicare shows only a Star Rating for this topic
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Members Choosing to Leave the Plan (D03):

Is there a valid numeric voluntary disenrollment rate?
- Yes: Display the numeric voluntary disenrollment rate
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

MPF Price Accuracy measure (D07):

Is the contract effective date > 9/30/2022?
- Yes: Display message: Plan too new to be measured
- No: Does contract have at least 30 claims over the measurement period for the price accuracy index?
  - Yes: Display the numeric price accuracy rate
  - No: Is the organization type 1876 Cost and does not offer Drugs?
    - Yes: Display message: Plan not required to report measure
    - No: Display message: Not enough data available

Patient Safety measures – Adherence (D08 - D10) & SUPD (D12):

Does the contract offer Part D?

Yes: Is the contract effective date > 12/31/2022?
- Yes: Display message: Plan too new to be measured
- No: Does contract have 30 or fewer enrolled beneficiary member years (measure denominator)?
  - Yes: Display message: Not enough data available
  - No: Display numeric measure percentage

No: Plan not required to report measure

Patient Safety measure – MTM CMR (D11)

Is the contract effective date > 12/31/2022?
- Yes: Display message: Plan too new to be measured
- No: Is Part D offered?
  - Yes: Is there a numeric rate?
    - Yes: Display numeric measure percentage
    - No: Is there a Reason(s) for Display Message?
      - Yes: Display appropriate message per table Q-2
  - No: Display message: Plan not required to report measure

Table Q-2: MTM CMR Reason(s) for Display Message conversion

Reason(s) for Display Message	Star Ratings Message
Contract failed to submit file and pass system validation by the reporting deadline	CMS identified issues with this plan's data
Contract did not pass element-level DV for at least one element	CMS identified issues with this plan's data
Contract had missing score on MTM section DV	CMS identified issues with this plan's data
Contract scored less than 95% on MTM section DV	CMS identified issues with this plan's data
Contract had all plans terminate by validation deadline	No data available
Contract had no MTM enrollees to report	No data available
Contract has 0 Part D enrollees	No data available
Contract had 30 or fewer beneficiaries meeting denominator criteria	Not enough data available
Contract not required to submit MTM program	Not required to report

Domain, Summary, and Overall level messages

Table Q-3 contains all of the possible messages that could be assigned to missing data at the domain, summary, and overall levels.

Table Q-3: Domain, Summary, and Overall level missing data messages

Message	Domain Level	Summary & Overall Level
Coming Soon	Used for all domain ratings in MPF between Oct 1 and when the actual Star Rating data go live	Used for all summary and overall ratings in MPF between Oct 1 and when the actual Star Rating data go live
Not enough data available	The contract did not have enough rated measures to calculate the domain rating	The contract did not have enough rated measures to calculate the summary or overall rating
Plan too new to be measured	The contract is too new to have submitted measure data for a domain rating to be calculated	The contract is too new to have submitted data to be rated in the summary or overall levels

Assignment rules for Part C & Part D domain rating level messages

Part C & D domain message assignment rules:

Is there a numeric domain star?
- Yes: Display the numeric domain star
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Assignment rules for Part C & Part D summary rating level messages

Part C & D summary rating message assignment rules:

Is there a numeric summary rating star?
- Yes: Display the numeric summary rating star
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Assignment rules for overall rating level messages

Overall rating message assignment rules:

Is there a numeric overall rating star?
- Yes: Display the numeric overall rating star
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Disenrollment Reasons messages

The 2024 Star Ratings posted to the CMS downloadable Master Table and HPMS includes data collected from the Disenrollment Reasons Survey (DRS). The DRS data was not used at any point in the calculation of the Star Ratings. The data are provided for information only at this time and are shown in HPMS with the Star Ratings data and on the display page at http://go.cms.gov/partcanddstarratings.

Because there are instances where a contract does not have data to display, a set of rules was developed to assign messages where data was missing so the data area would not be left blank.
Table Q-4 contains all of the possible messages that could be assigned to missing data in the disenrollment reason data displayed in HPMS.

Table Q-4: Disenrollment Reason missing data messages

Message	Meaning
Not Applicable	Used when the DRS measure does not apply to the contract type
Not Available	Used when there is no numeric data available, or data reliability indicated the value should be suppressed
Plan too new to be measured	The contract is too new for data to be collected for the measure

Disenrollment Reasons message assignment rules:

Is the contract effective date > 1/1/2022?
- Yes: Display message: Plan too new to be measured
- No: Is there numeric data for the contract in this DRS measure?
  - Yes: Did the data reliability check indicate the data should be suppressed?
    - Yes: Display message: Not Available
    - No: Display the numeric DRS rate
  - No: Does the DRS measure apply to the organization type
    - Yes: Display message: Not Available
    - No: Display message: Not Applicable

AEP	The annual period from October 15 until December 7 when a Medicare beneficiary can enroll into a Medicare Part C or D plan or re-enroll into their existing Medicare Part C or D Plan or change into another Medicare plan is known as the Annual Election Period (AEP). The chosen Medicare Part C or D plan coverage begins on January 1st.
C-SNP	Chronic Condition Special Needs Plans (C-SNPs) are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2.
CAHPS	The term CAHPS refers to a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care. CAHPS surveys probe those aspects of care for which consumers and patients are the best and/or only source of information, as well as those that consumers and patients have identified as being important. CAHPS initially stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the acronym now stands for Consumer Assessment of Healthcare Providers and Systems.
CCP	A Coordinated Care Plan (CCP) is a health plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by CMS. The CCP network is approved by CMS to ensure that all applicable requirements are met, including access and availability, service area, and quality requirements. CCPs may use mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care. CCPs include HMOs, PSOs, local and regional PPOs, and senior housing facility plans. SNPs can be offered under any type of CCP that meets CMS's requirements.
Cohort	A cohort is a group of people who share a common designation, experience, or condition (e.g., Medicare beneficiaries). For the HOS, a cohort refers to a random sample of Medicare beneficiaries that is drawn from each Medicare Advantage Organization (MAO) with a minimum of 500 enrollees and surveyed every spring (i.e., a baseline survey is administered to a new cohort each year). Two years later, the baseline respondents are surveyed again (i.e., follow up measurement). For data collection years 1998-2006, the MAO sample size was 1,000. Effective 2007, the MAO sample size was increased to 1,200.
Cost Plan	A plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan in accordance with a cost reimbursement contract under §1876(h) of the Act. In the Star Ratings, CMS classifies a Cost Plan not offering Part D as MA-Only and a Cost Plan offering Part D as MA-PD.
D-SNP	Dual Eligible Special Needs Plans (D-SNPs) enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Disability Status	Based on the original reason for entitlement for Medicare (Disability insurance benefits or both Disability insurance benefits and End-Stage Renal Disease).
Dual eligibles	Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.
Euclidean distance	The absolute value of the difference between two points, x-y.
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
HOS	The Medicare Health Outcomes Survey (HOS) is the first patient reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS program is to gather valid, reliable, and clinically meaningful health status data in the Medicare Advantage (MA) program for use in quality improvement activities, pay for performance, program oversight, public reporting, and improving health. All managed care organizations with MA contracts must participate.
I-SNP	Institutional Special Needs Plans (I-SNPs) are SNPs that restrict enrollment to institutionalized special needs individuals defined in 42 CFR 422.2.
IRE	The Independent Review Entity (IRE) is an independent entity contracted by CMS to review Medicare health and drug plans' adverse reconsiderations of organization determinations.
LIS	The Low Income Subsidy (LIS) from Medicare provides financial assistance for beneficiaries who have limited income and resources. Those who receive the LIS get help paying for their monthly premium, yearly deductible, prescription coinsurance, and copayments and they will have no gap in coverage.
LIS/DE	Beneficiaries who qualify at any point in the year for a low income subsidy through the application process and/or who are full or partial Dual (Medicare and Medicaid) beneficiaries.
MA	A Medicare Advantage (MA) organization is a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.
MA-Only	An MA organization that does not offer Medicare prescription drug coverage.
MA-PD	An MA organization that offers Medicare prescription drug coverage and Part A and Part B benefits in one plan.
MSA	Medicare Medical Savings Account (MSA) plans combine a high deductible MA plan and a medical savings account (which is an account established for the purpose of paying the qualified medical expenses of the account holder).
Percentage	A part of a whole expressed in hundredths. For example, a score of 45 out of 100 possible points is the same as 45%.

Percentile	The value below which a certain percent of observations fall. For example, a score equal to or greater than 97 percent of other scores attained on the same measure is said to be in the 97th percentile.
PDP	A Prescription Drug Plan (PDP) is a stand-alone drug plan, offered by insurers and other private companies to beneficiaries who receive their Medicare Part A and/or B benefits either through the Original Medicare Plan, Medicare Private Fee-for-Service Plans that do not offer prescription drug coverage, or Medicare Cost Plans that do not offer Medicare prescription drug coverage.
PFFS	Private Fee-for-Service (PFFS) is defined as an MA plan that pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; does not vary the rates for a provider based on the utilization of that provider's services; and does not restrict enrollees' choices among providers who are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment. The Medicare Improvements for Patients and Providers Act (MIPPA) added that although payment rates cannot vary based solely on utilization of services by a provider, a PFFS plan is permitted to vary the payment rates for a provider based on the specialty of the provider, the location of the provider, or other factors related to the provider that are not related to utilization. Furthermore, MIPPA also allows PFFS plans to increase payment rates to a provider based on increased utilization of specified preventive or screening services. See section 30.4 of the Medicare Managed Care Manual Chapter 1 for further details on PFFS plans.
Reliability	A measure of the fraction of the variation among the observed measure values that is due to real differences in quality (“signal”) rather than random variation (“noise”). On a scale from 0 (all differences among plans are due to randomness of sampling) to 1 (every plan's quality is measured with perfect accuracy).
SNP	A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limits enrollment to special needs individuals. A special needs individual could be any one of the following: 1) an institutionalized individual, 2) a dual eligible beneficiary, or 3) an individual with a severe or disabling chronic condition, as specified by CMS. A SNP may be any type of MA CCP. There are three major types of SNPs: 1) Chronic Condition SNP (C-SNP), 2) Dual Eligible SNP (D-SNP), and 3) Institutional SNP (I-SNP).
Sponsor	An entity that sponsors a health or drug plan.
Statistical Significance	Statistical significance assesses how likely differences observed are due to chance when plans are actually the same. CMS uses statistical tests (e.g., t-test) to determine if a contract’s measure value is statistically significantly greater or less than the national average for that measure, or whether conversely the observed differences from the national average could have arisen by chance.
Sum of Squares	Method used to measure variation or deviation from the mean.
TTY	A teletypewriter (TTY) is an electronic device for text communication via a telephone line, used when one or more of the parties has hearing or speech difficulties.

Very Low Reliability	For CAHPS, an indication that reliability is less than 0.6, indicating that 40% or more of observed variation is due to random noise.

Attachment S: Health Plan Management System Module Reference

This attachment is designed to assist reviewers of the data displayed in HPMS (https://hpms.cms.gov) to understand the various pages and fields shown in the HPMS Star Ratings module. This module employs standard HPMS user access rights so that users can only see contracts associated with their user id.

HPMS Star Ratings Module

The HPMS Star Ratings module contains the Part C & Part D data and stars for all contracts that were rated in the ratings year along with much of the detailed data that went into the various calculations. To access the Star Ratings module you must be logged into HPMS. If you do not have access to HPMS, information on how to obtain access can be found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/Overview.html

Once you are logged into HPMS, from the home page, select *Performance Metrics* from the *Quality and Performance* menu; the Performance Metrics page will be displayed. If you do not see *Performance Metrics*, your user id does not have the correct access permissions; please contact CMSHPMS_Access@cms.hhs.gov From the Performance Metrics page, select *Reports* and then *Star Ratings and Display Measures* from the left side menu. The *Star Ratings and Display Measures* home page will be displayed.

On the *Star Ratings and Display Measures* home page, select *Star Ratings* as the Report Type and select a reporting period. The remainder of this attachment describes the HPMS pages available for the 2024 Star Ratings.

1. Measure Data page

The Measure Data page displays the numeric data for all Part C and Part D measures. This page is available during the first plan preview.

The first four columns contain contract identifying information. The remaining columns contain the measures which will display in MPF. There is one column for each of the Part C and Part D measures. The measure columns are identified by measure id and measure name. The row immediately above this measure information contains the domain name. The row immediately below the measure information contains the data time frame of the measure. All subsequent rows contain the data for all individual contracts associated with the user's login id. Table S-1 below shows a sample of the left hand most columns shown in HPMS.

Table S-1: Measure Data page sample

Medicare Star Ratings Report Card Master Table

				HD1: Staying Healthy: Screenings, Tests and Vaccines		
				C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine
Contract Number	Organization Marketing Name	Contract Name	Parent Organization	01/01/2022 - 12/31/2022	01/01/2022 - 12/31/2022	03/2023 - 06/2023
HAAAA	Market A	Contract A	PO A	Plan too new to be measured	Plan too new to be measured	Not enough data available
HBBBB	Market B	Contract B	PO B	Not enough data available	73%	81%
HCCCC	Market C	Contract C	PO C	63%	71%	80%

2. Measure Detail – CTM Summary page

The Measure Detail – CTM Summary page contains the underlying data used for the Part C and Part D Complaints (C25/D02) measures. This page is available during the first plan preview. Table S-2 below explains each of the columns displayed on this page.

Table S-2: Measure Detail – CTM Summary page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Total Number of Complaints	Number of non-excluded complaints for the contract
Complaint Average Enrollment	The average enrollment used in the final calculation
Complaints Less Than 800 Enrolled	Yes / No, Yes = average enrollment less than 800, No = average enrollment greater than or equal to 800

3. Measure Detail – Part C Appeals page

The Measure Detail – Part C Appeals page contains the case-level data of the non-excluded cases used in producing the Part C Appeals measures Plan Makes Timely Decisions about Appeals (C28) and Reviewing Appeals Decisions (C29). The data displayed on this page reflect the state of the appeals case at the time the data were pulled for use in the 2024 Star Ratings. This page is available during the first plan preview. Table S-3 below explains each of the columns displayed on this page.

Table S-3: Measure Detail – Part C Appeals page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
Appeal Number	The case ID assigned to the appeal request
Appeal Priority	The priority of the appeal (Std Pre-Service, Exp Pre-Service, Pre-Service B Drug, or Retro)
Status	The status of the appeal (Closed, Decided, Pending, Promoted, Remanded, Reopened, Requested)
Date Appeal Filed	The Date the Plan Reconsideration was requested, as reported by the Part C Plan
Corrected Appeal Date	The Date Appeal Filed, as determined by the IRE/QIC
Date File Received (QIC)	The Date the IRE/QIC received the Appeal from the Part C Plan
Level 1 Extension	Indicates if the contract took an extension during their processing of the reconsideration, as reported by the contract
Adjusted Plan Interval	The number of days between the Date Appeal Filed (or Corrected Appeal Date, if applicable) and the Date File Received (QIC) adjusted based on the Appeal Priority (Std Pre-Service, Exp Pre-Service, or Retro) and adjusted to account for 5 mailing days
Appeal Decision	Decision associated with the appeal: Dismiss Appeal, Dismissed – Plan Approved Coverage, Favorable (Overturn MCO Denial), Partially Favorable (Partly Overturn MCO Denial), Unfavorable (Uphold MCO Denial), Withdraw Appeal, Remand to Plan.
Late Indicator	Indicates if the appeal case was considered late or not (0=Not Late, 1=Late)

4. Measure Detail – SNP CM page

The Measure Detail – SNP CM page contains the underlying data used in calculating the Part C SNP Care Management measure (C05). The formulas used to calculate the SNP CM measure are detailed in Attachment E. This page is available during the first plan preview. Table S-4 below explains each of the columns displayed on this page.

Table S-4: Measure Detail – SNP CM page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Number of new enrollees	Number of new SNP enrollees eligible for an initial assessment (Data Element A)
Number of enrollees eligible for an annual HRA	Number of SNP enrollees eligible for an annual reassessment (Data Element B)
Number of initial HRAs performed on new enrollees	Number of initial assessments performed on new SNP enrollees (Data Element C)
Number of annual reassessments performed	Number of annual reassessments performed on eligible SNP enrollees (Data Element F)
Total Number of SNP Enrollees Eligible	Final measure numerator (Data Elements A + B)
Total Number of Assessments Performed	Final measure denominator (Data Elements C + F)
Percent of Eligible SNP Enrollees Receiving an Assessment	Final measure score
Data Validation Score	The data validation score for the contract
Reason for Exclusion	Reason (if any) contract submitted data was not used to generate a score

5. Measure Detail – HEDIS page

The Measure Detail – HEDIS page contains the underlying data used in calculating the Part C HEDIS SNP Care for Older Adults measures, the Transitions of Care measure and the Plan All-Cause readmissions measure. The formulas used to calculate the SNP measures are detailed in Attachment E. The formula used to calculate the PCR measure is detailed in Attachment F. This page is available during the first plan preview. Table S-5 below explains each of the columns displayed on this page and Table S-6 explains the HEDIS audit designations.

Table S-5: Measure Detail – HEDISpage fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
PBP ID	The Plan Benefit Package number associated with the data
Measure ID	The Star Ratings measure ID that corresponds to the data in the given row
Measure Name	The measure name that corresponds to the data in the given row
Rate	The measure rate
Eligible Population	The measure eligible population
Observed Count	The measure observed count (only applicable for PCR)
Expected Count	The expected count (only applicable for PCR)
Denominator	The measure denominator
Audit Designation	The audit designation (the audit codes are defined in the next table)
Status	The status (the status codes are defined in the next table)
Average Plan Enrollment	The average enrollment in the PBP during 2022 (see section Contract Enrollment Data)

Table S-6: HEDIS 2022 Audit Designations and 2024 Star Ratings

Audit Designation	Status	NCQA Description	Resultant Star Rating
R	R	Reportable	Assigned 1 to 5 stars depending on reported value
BR	R or NA	Biased Rate	1 star, numeric data set to "CMS identified issues with this plan's data"
R	NA	Small Denominator	"Not enough data available"
NB	R or NA	No Benefit	"Benefit not offered by plan"
NR	R or NA	Not Reported	1 star, numeric data set to "CMS identified issues with this plan's data"
NQ	R or NA	Not Required	"Plan not required to report measure" (applies only to 1876 Cost in the PCRb measure)
UN		Un-Audited	Not possible in Star Ratings measures which only use audited data

6. Measure Detail – CTM page

The Measure Detail – CTM page contains the case level data of the non-excluded cases used in producing the Part C & Part D Complaints measure (C25/D02). This page is available during the first plan preview. Table S-7 below explains each of the columns displayed on this page.

Table S-7: Measure Detail – CTM page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Complaint ID	The case number associated with the complaint in the HPMS CTM module
Complaint Category	The complaint category code
CMS Issue	Is the complaint designated as a CMS issue? (Yes/No)
Category	The complaint category description of CMS or plan lead
Subcategory	The complaint subcategory description associated with this case
Subcategory — Other	The complaint additional subcategory description associated with this case
Contract Assignment / Reassignment Date	The date that complaints are assigned or re-assigned to contracts

7. Measure Detail – Disenrollment

The Measure Detail – Disenrollment page contains data that are used in calculating the Part C & Part D disenrollment measure (C26/D03). The page shows the denominator, unadjusted numerator and original rate received from the MBDSS annual report. It also contains the adjusted numerator and final rate after all members meeting the measure exclusion criteria described in the measure description have been removed. This page is available during the first plan preview. Table S-8 below explains each of the columns displayed on this page.

Table S-8: Measure Detail – Disenrollment page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
Number Enrolled	The number of all members in the contract from MBDSS annual report
Number Disenrolled	The number disenrolled with a disenrollment reason code of 11, 13, 14 or 99, from the MBDSS annual report
Original Rate	The disenrollment rate as calculated by the annual MBDSS report
Adjusted Disenrolled	The adjusted numerator when all members who meet the measure exclusion criteria are removed
Adjusted Rate	The final adjusted disenrollment rate used in the Star Ratings
>1000 Enrolled	Flag indicates contract non-employer group enrollment >1,000 members during the year or contracts that did not have any disenrollments meeting the inclusion criteria (True = Yes, False = No)

8. Measure Detail – DR (Disenrollment Reasons)

The Measure Detail – Disenrollment Reasons page contains the data from the Disenrollment Reasons Survey (DRS). The Disenrollment Reasons data are not used at any point in the calculations of the Star Ratings but are provided in HPMS for information only at this time. The data come from surveys sent to enrollees who disenrolled between 1/1/2022 and 12/31/2022. Scores are suppressed if they are measured with very low reliability (< 0.60) and not statistically different from the national mean. This page is available during the first plan preview. Table S-9 below explains each of the columns displayed on this page.

Table S-9: Measure Detail – Disenrollment Reasons page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
DR PGPPPNC	Disenrollment Reasons - Problems Getting the Plan to Provide and Pay for Needed Care (MA-PD, MA-Only)
DR PCDH	Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-Only)
DR FRD	Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-Only, PDP)
DR PPDBC	Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)
DR PGIHP	Disenrollment Reasons - Problems Getting Information and Help from the Plan (MA-PD, PDP)

9. Measure Detail – MTM page

The Measure Detail – MTM page contains each contract's underlying denominator and numerator after measure specifications have been applied to the plan-reported validated data to calculate the Part D MTM Program Completion Rate for CMR (D11). The formulas used to calculate the MTM measure are detailed in Attachment N. This page is available during the first plan preview. Table S-10 below explains each of the columns displayed on this page.

Table S-10: Measure Detail – MTM page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Total Part D Enrollees	The number of Part D enrollees in the contract (average monthly HPMS enrollment)
Total MTM Enrollees, All	The number of Part D enrollees enrolled in the contract's MTM program (as reported in the Part D MTM plan-reported data). Includes beneficiaries that had an enrollment start date anytime in the measurement period, regardless of age, hospice status, or duration of MTM enrollment. Excludes records where the MBI could not be mapped to a valid beneficiary or where the beneficiary was reported with multiple, conflicting records in the same contract's data.
Total MTM Enrollees, Targeted	The number of Part D enrollees enrolled in the contract's MTM program that met the specified targeting criteria per CMS-Part D requirements pursuant to §423.153(d) of the regulations (as reported in the Part D MTM plan-reported data). Includes beneficiaries that had an enrollment start date anytime in the measurement period, regardless of age, hospice status, or duration of MTM enrollment. Excludes records where the MBI could not be mapped to a valid beneficiary or where the beneficiary was reported with multiple, conflicting records in the same contract's data.
Total MTM Enrollees, Targeted, Adjusted	The number of Part D enrollees enrolled in the contract's MTM program that met the specified targeting criteria per CMS-Part D requirements pursuant to §423.153(d) of the regulations (as reported in the Part D plan-reported data) after measure specifications applied as detailed in Attachment N. (Measure Denominator)
Total MTM Enrollees, Targeted, Adjusted, Who Received a CMR	The number of beneficiaries from the denominator who received a CMR. (Measure Numerator)
MTM Program Completion Rate for CMR	The percent of MTM program enrollees who received a CMR. (Measure Numerator)/(Measure Denominator)
MTM Section Data Validation Score	Contract's score in data validation (DV) for their MTM Program Reporting Requirements data
Reason(s) for Display Message	Reason(s) for display message assignment (if applicable)

10. Measure Detail – CAHPS page

The Measure Detail – CAHPS page contains the underlying data used in calculating the Part C & D CAHPS measures: Annual Flu Vaccine (C03), Getting Needed Care (C19), Getting Appointments and Care Quickly (C20), Customer Service (C21), Rating of Health Care Quality (C22), Rating of Health Plan (C23), Care Coordination (C24), Rating of Drug Plan (D05), and Getting Needed Prescription Drugs (D06). This page is available during the first plan preview. Table S-11 below explains each of the columns displayed on this page.

Table S-11: Measure Detail – CAHPS page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
CAHPS Measure	The CAHPS measure identifier followed by the Star Ratings measure id in parenthesis
Reliability	The contract-level reliability of the measure data
Statistical Significance	The statistical significance of the measure data (Below Average, No Difference, Above Average)
Use N	The number of usable surveys with responses to the item, or at least one item of a composite
Mean Score on Original Scale	The mean score on the original survey response scale
Variance of Mean on Original Scale	The sampling variance of contract mean ("Mean score") on the original scale
Standard Error on Original Scale	The standard error of the contract mean ("Mean score") on the original scale; square root of "variance"
Scaled Mean	The contract mean score rescaled to a 0-100 scale
Scaled SE	The standard error of the 0-100 scaled mean
Base Group	Categories determined by the percentile cutoffs from the distribution of mean scores
Star Rating	Determined by the percentile cutoffs, statistical significance of the difference of the contract mean from the overall mean, the statistical reliability of the estimate, and standard error of the mean score

11. Calculation Detail – MD

The Calculation Detail – MD page contains the summary of service area and enrollment data used to calculate the percentages for use in the Major Disaster rules for the individual measures. This page is available during the first plan preview. Table S-12 below explains the columns displayed on this page.

Table S-12: Calculation Detail – MD page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
Disaster Flag 2022	Indicates if the contract was affected by a 2022 disaster or not (valid values "Affected", "Not Affected" or "Too New")
Total Cnty in SA 2022	The total number of counties in the contract's 2022 service area (SA)
Num Cnty IA 2022	The number of counties from the contract's total SA designated as FEMA Individual Assistance (IA) counties in a 2022 disaster
IA Enrolled 2022	The number of members residing in the contract SA designated FEMA IA counties in a 2022 disaster
Total Enrolled 2022	The total number of members residing in the contract's 2022 SA
IA % 2022	The percent of members living in IA areas in a 2022 disaster (IA Enrolled)/(Total Enrolled)
IA % Rounded 2022	The percent of members living in IA areas in a 2022 disaster rounded to an integer
greater than 25% 2022	Flag that indicates if the contract has met the 25% threshold for 2022 disasters (Yes: greater than or equal to 25%, No: less than 25%)
greater than 60% 2022	Flag that indicates if the contract has met the 60% threshold for 2022 disasters (Yes: greater than or equal to 60%, No: less than 60%)
Disaster Flag 2021	Indicates if the contract was affected by a 2021 disaster or not (valid values "Affected", "Not Affected" or "Too New")
Total Cnty in SA 2021	The total number of counties in the contract's 2021 service area (SA)
Num Cnty IA 2021	The number of counties from the contract's total SA designated as FEMA Individual Assistance (IA) counties in a 2021 disaster
IA Enrolled 2021	The number of members residing in the contract SA designated FEMA IA counties in a 2021 disaster
Total Enrolled 2021	The total number of members residing in the contract's 2021 SA
IA % 2021	The percent of members living in IA areas in a 2021 disaster (IA Enrolled)/(Total Enrolled)
IA % Rounded 2021	The percent of members living in IA areas in a 2021 disaster rounded to an integer
greater than or equal to 25% 2021	Flag that indicates if the contract has met the 25% threshold for 2021 disasters (Yes: greater than or equal to 25%, No: less than 25%)

12. Calculation Detail – CAI

The Calculation Detail – CAI page contains the enrollment data used to calculate the percentages for use in the Categorical Adjustment Index (CAI) to determine the Final Adjustment Categories for each of the summary and overall rating calculations. This page is available during the first plan preview. Table S-13 below explains the columns displayed on this page.

Table S-13: Measure Detail – CAI page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Puerto Rico Only	Does the contract's non-employer service area only cover Puerto Rico? Yes or No
Contract Type	The contract plan type used to compute the ratings
Part D Offered	Is Part D offered by the contract? Yes or No
Enrolled	The total number enrolled in the contract used to determine the % LIS/DE and % Disabled
Num LIS/DE	The number of LIS/DE enrolled in the contract
Num Disabled	The number of Disabled enrolled in the contract
% LIS/DE	The percent of LIS/DE in the contract
% Disabled	The percent Disabled in the contract
Part C LIS/DE Initial Group	The Part C LIS/DE initial group this contract is in
Part C Disabled Quintile	The Part C Disabled Quintile group this contract is in
Part C FAC	The Part C Final adjustment category this contract is in
Part C CAI Value	The CAI value that will be combined with the final Part C summary score prior to rounding to half stars
Part D MA-PD LIS/DE Initial Group	The Part D MA-PD LIS/DE initial group this contract is in
Part D MA-PD Disabled Quintile	The Part D MA-PD Disabled Quintile group this contract is in
Part D MA-PD FAC	The Part D MA-PD Final adjustment category this contract is in
Part D MA-PD CAI Value	The CAI value that will be combined with the final Part D MA-PD summary score prior to rounding to half stars
Part D PDP LIS/DE Quartile	The Part D PDP LIS/DE Quartile group this contract is in
Part D PDP Disabled Quartile	The Part D PDP Disabled Quartile group this contract is in
Part D PDP FAC	The Part D PDP Final adjustment category this contract is in
Part D PDP CAI Value	The CAI value that will be combined with the final Part D PDP summary score prior to rounding to half stars
Overall LIS/DE Initial Group	The overall LIS/DE initial group this contract is in
Overall Disabled Quintile	The overall disabled Quintile group this contract is in
Overall FAC	The overall final adjustment category this contract is in
Overall CAI Value	The CAI value that will be combined with the final overall score prior to rounding to half stars

13. Measure Detail – HEDIS LE page

The Measure Detail – HEDIS LE page contains the data used to calculate the reliability of the HEDIS measures (C01, C02, C08 – C11, C14 – C18) data for contracts with $\geq$ 500 and $<$ 1,000 members enrolled in July of the measurement year (July 01, 2022). This page is available during the second plan preview. Table S-14 below explains each of the columns displayed on this page.

Table S-14: Measure Detail – HEDIS LE page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
Measure ID	The Star Ratings measure that the other data on this row is associated with
Rate	The submitted HEDIS rate
Score	The rounded value used for the measure in the Star Ratings
Enrollment	The contract enrollment for July 2022
Reliability	The computed reliability for the contract measure
Usable	The computed reliability ≥ 0.7 and rate is used = True, reliability < 0.7 and rate was not used = False

14. Measure Detail – C MD Results

The Part C Disaster Results page displays the measure level data handling results for contracts which had ≥25% of their enrollment living in areas affected by major disasters during the measurement period. Only the measures where the disaster policy required a comparison between two ratings years are displayed in the data. This page is available during the second plan preview. Table S-15 below explains the columns displayed on this page.

Table S-15: Measure Detail – C MD Results

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Measure ID	The 2024 Star Ratings Part C measure ID
2023 Value	The numeric measure value for the contract from the 2023 Star Ratings
2023 Star	The measure star for the contract from the 2023 Star Ratings
2024 Value	The numeric measure value for the contract from the 2024 Star Ratings
2024 Star	The measure star for the contract from the 2024 Star Ratings
Final Value	The measure value to be used in the 2024 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2024 Star Ratings after the data handling policy for disasters was applied
Final From	The Star Ratings year where the final data for the measure came from

15. Measure Detail – D MD Results

The Part D Disaster Results page displays the measure level data handling results for contracts which had greater than or equal to 25% of their enrollment living in areas affected by major disasters during the measurement period. Only the measures where the disaster policy required a comparison between two ratings years are displayed in the data. This page is available during the second plan preview. Table S-16 below explains the columns displayed on this page.

Table S-16: Measure Detail – D MD Results

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Measure ID	The 2024 Star Ratings Part D measure ID
2023 Value	The numeric measure value for the contract from the 2023 Star Ratings
2023 Star	The measure star for the contract from the 2023 Star Ratings
2024 Value	The numeric measure value for the contract from the 2024 Star Ratings
2024 Star	The measure star for the contract from the 2024 Star Ratings
Final Value	The measure value to be used in the 2024 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2024 Star Ratings after the data handling policy for disasters was applied
Final From	The Star Ratings year where the final data for the measure came from

16. Measure Detail – C Improvement page

The Improvement page is constructed in a similar manner as the Measure Data page. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the results of the improvement calculation for the specific Part C measures. There is one column for each Part C measure. The measure columns are identified by measure id and measure name. There is an additional column to the right of the Part C measure columns which contains the final numeric Part C improvement score. This numeric result is described in Attachment I: "Calculating the Improvement Measure and the Measures Used."

The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains a flag (Included or Not Included) to show if the measure was used to calculate the final improvement measure. All subsequent rows contain the data associated with an individual contract. The possible results for Part C measure calculations are shown in Table S-17 below.

Table S-17: Part C Measure Improvement Results

Improvement Measure Result	Description
No significant change	There was no significant change in the values between the two years
Significant improvement	There was a significant improvement from last year to this year
Significant decline	There was a significant decline from last year to this year
Not included in calculation	There was only one year of data available so the calculation could not be completed
Not Applicable	The measure is not an improvement measure
Not Eligible	The contract did not have data in more than half of the improvement measures or was too new
Held Harmless	The contract had 5 stars in this measure last year and this year
Low reliability and low enrollment	The low-enrollment contract measure score did not have sufficiently high reliability

17. Measure Detail – D Improvement page

The Improvement page is constructed in a similar manner as the Measure Data page. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the results of the improvement calculation for the specific Part D measures. There is one column for each Part D measure. The measure columns are identified by measure id and measure name. There is an additional column to the right of the Part D measure columns which contains the final numeric Part D improvement score. This numeric result is described in Attachment I: "Calculating the Improvement Measure and the Measures Used."

The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains a flag (Included or Not Included) to show if the measure was used to calculate the final improvement measure. All subsequent rows contain the data associated with an individual contract. The possible results for Part D measure calculations are shown in Table S-18 below.

Table S-18: Part D Measure Improvement Results

Improvement Measure Result	Description
No significant change	There was no significant change in the values between the two years
Significant improvement	There was a significant improvement from last year to this year
Significant decline	There was a significant decline from last year to this year
Not included in calculation	There was only one year of data available so the calculation could not be completed
Not Applicable	The measure is not an improvement measure
Not Eligible	The contract did not have data in more than half of the improvement measures or was too new
Held Harmless	The contract had 5 stars in this measure last year and this year

18. Measure Stars page

The Measure Stars page displays the Star Rating for each Part C and Part D measure. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the measure stars which will display in MPF. There is one column for each of the Part C and Part D measures. The measure columns are identified by measure id and measure name. The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains the data time frame. All subsequent rows contain the data for all individual contracts associated with the user's login id. Table S-19 below shows a sample of the left hand most columns shown in HPMS.

Table S-19: Measure Stars page sample

Medicare Star Ratings Report Card Master Table

					HD1: Staying Healthy: Screenings, Tests and Vaccines		
					C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine
Contract Number	Organization Marketing Name	Contract Name	Parent Organization		01/01/2022 - 12/31/2022	01/01/2022 - 12/31/2022	03/2023 - 06/2023
HAAAA	Market A	Contract A	PO A	Plan too new to be measured	Plan too new to be measured	Not enough data available	
HBBBB	Market B	Contract B	PO B	Not enough data available	4	5	
HCCCC	Market C	Contract C	PO C	3	4	5	

19. Domain Stars page

The Domain Stars page displays the Star Rating for each Part C and Part D domain. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the domain stars which will display in MPF. There is one column for each of the Part C and Part D domains. The domain columns are identified by the domain id and domain name. All subsequent rows contain the stars associated with an individual contract. Table S-20 below shows a sample of the left hand most columns shown in HPMS.

Table S-20: Domain Star page sample

Medicare Star Ratings Report Card Master Table

Contract Number	Organization Marketing Name	Contract Name	Parent Organization	HD1: Staying Healthy: Screenings, Tests and Vaccines	HD2: Managing Chronic (Long Term) Conditions	HD3: Member Experience with Health Plan
HAAAA	Market A	Contract A	PO A	4	3	4
HBBBB	Market B	Contract B	PO B	3	3	3
HCCCC	Market C	Contract C	PO C	3	3	4

20. Part C Summary Rating page

The Part C Summary Rating page displays the Part C rating and data associated with calculating the final Part C summary rating. This page is available during the second plan preview. There are flags to indicate if the final rating came from the without improvement measures calculation. Table S-21 below explains each of the columns contained on this page.

Table S-21: Part C Summary Rating page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Contract Type	The contract plan type used to compute the ratings
SNP Plans	Does the contract offer a SNP? (Yes/No)
Major Disaster Percentage 2021	The percentage of members living in an Individual Assistance area in 2021 rounded to an integer
Major Disaster Percentage 2022	The percentage of members living in an Individual Assistance area in 2022 rounded to an integer
Number Measures Required	The minimum number of measures required to calculate a rating out all required for the contract type.
Number Missing Measures	The number of measures that were missing stars
Number Rated Measures	The number of measures that were assigned stars
Calculated Summary Mean	Contains the mean of the stars for rated measures
Calculated Variance	The variance of the calculated summary mean
Calculated Score Percentile Rank	Percentile ranking of Calculated Summary Mean
Variance Percentile Rank	Percentile ranking of Calculated Variance
Variance Category	The reward factor variance category for the contract (low, medium, or high)
Reward Factor	The calculated reward factor for the contract (0, 0.1, 0.2, 0.3, or 0.4)
Interim Summary	The sum of the Calculated Summary Mean and the Reward Factor
Part C Summary FAC	Part C summary final adjustment category for the contract
CAI Value	The Part C summary CAI value for the contract
Final Summary	The sum of the Interim Summary and the CAI Value

HPMS Field Label	Field Description
Improvement Measure Usage	Did the final Part C summary rating come from the calculation using the improvement measure? (Yes/No)
New Measure Usage	Did the final Part C summary rating come from the calculation using the new measures? (Yes/No)
2024 Part C Summary Rating	The final rounded 2024 Part C Summary Rating

21. Part D Summary Rating page

The Part D Summary Rating page displays the Part D rating and data associated with calculating the final Part D summary rating. This page is available during the second plan preview. There are flags to indicate if the final rating came from the without improvement measures calculation. Table S-22 below explains each of the columns contained on this page.

Table S-22: Part D Summary Rating View

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Contract Type	The contract plan type used to compute the ratings
Major Disaster Percentage 2021	The percentage of members living in an Individual Assistance area in 2021 rounded to an integer
Major Disaster Percentage 2022	The percentage of members living in an Individual Assistance area in 2022 rounded to an integer
Number Measures Required	The minimum number of measures required to calculate a rating out all required for the contract type
Number Missing Measures	The number of measures that were missing stars
Number Rated Measures	The number of measures that were assigned stars
Calculated Summary Mean	Contains the mean of the stars for rated measures
Calculated Variance	The variance of the calculated summary mean
Calculated Score Percentile Rank	Percentile ranking of Calculated Summary Mean
Variance Percentile Rank	Percentile ranking of Calculated Variance
Variance Category	The reward factor variance category for the contract (low, medium, or high)
Reward Factor	The calculated reward factor for the contract (0, 0.1, 0.2, 0.3, or 0.4)
Interim Summary	The sum of the Calculated Summary Mean and the Reward Factor
Part D Summary FAC	Part D summary final adjustment category for the contract
CAI Value	The Part D summary CAI value for the contract
Final Summary	The sum of the Interim Summary and the CAI Value
Improvement Measure Usage	Did the final Part D summary rating come from the calculation using the improvement measure? (Yes/No)
2024 Part D Summary Rating	The final rounded 2024 Part D Summary Rating

22. Overall Rating page

The Overall Rating page displays the overall rating for MA-PD contracts and data associated with calculating the final overall rating. This page is available during the second plan preview. There are flags to indicate if the final rating came from the without improvement measures calculation. Table S-23 below explains each of the columns contained on this page.

Table S-23: Overall Rating View

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Contract Type	The contract plan type used to compute the ratings
SNP Plans	Does the contract offer a SNP? (Yes/No)
Major Disaster Percentage 2021	The percentage of members living in an Individual Assistance area in 2021 rounded to an integer
Major Disaster Percentage 2022	The percentage of members living in an Individual Assistance area in 2022 rounded to an integer
Number Measures Required	The minimum number of measures required to calculate a rating out all required for the contract type
Number Missing Measures	The number of measures that were missing stars
Number Rated Measures	The number of measures that were assigned stars
2024 Part C Summary Rating	The 2024 Part C Summary Rating
2024 Part D Summary Rating	The 2024 Part D Summary Rating
Calculated Summary Mean	Contains the weighted mean of the stars for rated measures
Calculated Variance	The variance of the calculated summary mean
Calculated Score Percentile Rank	Percentile ranking of Calculated Summary Mean
Variance Percentile Rank	Percentile ranking of Calculated Variance
Variance Category	The reward factor variance category for the contract (low, medium, or high)
Reward Factor	The calculated reward factor for the contract (0, 0.1, 0.2, 0.3, or 0.4)
Interim Summary	The sum of the Calculated Summary Mean and the Reward Factor
Overall FAC	Overall final adjustment category for the contract
CAI Value	The Overall CAI value for the contract
Final Summary	The sum of the Interim Summary and the CAI Value
Improvement Measure Usage	Did the final overall rating come from the calculation using the improvement measures? (Yes/No)
New Measure Usage	Did the final overall rating come from the calculation using the new measures? (Yes/No)
2024 Overall Rating	The final 2024 Overall Rating

23. Low Performing Contract List

The Low Performing Contract List page displays the contracts that received a Low Performing Icon and the data used to calculate the assignment. This page is available during the second plan preview. HPMS users in contracting organizations will see only their own contracts in this list. None will be displayed if no contract in the organization was assigned a Low Performing Icon. Table S-24 below explains each of the columns contained on this page.

Table S-24: Low Performing Contract List

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Rated As	The type of rating for this contract, valid values are "MA-Only," "MA-PD," and "PDP"
2022 C Summary	The 2022 Part C Summary Rating earned by the contract
2022 D Summary	The 2022 Part D Summary Rating earned by the contract
2023 C Summary	The 2023 Part C Summary Rating earned by the contract
2023 D Summary	The 2023 Part D Summary Rating earned by the contract
2024 C Summary	The 2024 Part C Summary Rating earned by the contract
2024 D Summary	The 2024 Part D Summary Rating earned by the contract
Reason for LPI	The combination of ratings that met the Low Performing Icon rules. Valid values are "Part C," "Part D," "Part C and D," & "Part C or D." See the section titled "Methodology for Calculating the Low Performing Icon" for details.

24. High Performing Contract List

The High Performing Contract List page displays the contracts that received a High Performing Icon. This page is available during the second plan preview. HPMS users in contracting organizations will see only their own contracts in this list. None will be displayed if no contract in the organization was assigned a High Performing Icon. Table S-25 below explains each of the columns contained on this page.

Table S-25: High Performing Contract List

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Rated As	The type of rating for this contract, valid values are "MA-Only," "MA-PD," and "PDP"
Highest Rating	The highest level of rating that can be achieved for this organization, valid values are "Part C Summary," "Part D Summary," "Overall Rating"
Rating	The star value attained in the highest rating for the organization type

25. Technical Notes link

The Technical Notes link provides the user with a copy of the 2024 Star Ratings Technical Notes. A draft version of these technical notes is available during the first plan preview. The draft is then updated for the second plan preview, and then finalized when the ratings data have been posted to MPF. Other updates may occur to the technical notes if errors are identified outside of the plan preview periods and after MPF data release.

Left clicking on the Technical Notes link will open a new browser window which will display a PDF (portable document format) copy of the 2024 Star Ratings Technical Notes. Right clicking on the Technical Notes link will pop up a context menu which contains Save Target As…; clicking on this will allow the user to download and save a copy of the PDF document.

26. Medication NDC List

The Medication NDC List link provides the user a means to download a copy of the medication lists used for the Medication Adherence measures (D08 – D10) & SUPD (D12). This downloadable file is in Zip format and contains two Excel files.

27. Part C and Part D Example Measure Data

The Part C and Part D Example Measure Data link provides the user with a means to download a copy of the data for the Breast Cancer Screening Part C measure, and the Complaints about the Plan Part D measure and the MTM Program Completion Rate for CMR Part D measure for the full set of contracts used to calculate the cut points. The data are de-identified such that individual contract's data cannot be determined. The data include the measure value, a flag for contracts that had data issues, and two flags identifying contracts with >= 25 percent and >= 60 percent of enrollees living in an area affected by a disaster. There is also a flag in the Part C measure file to identify HEDIS low enrollment contracts. There is also a flag in the Part D measure files identifying contracts as MAPD or PDP. This downloadable is in Zip format and contains three Excel files.

TAB 26

From: Michael Plumb
To: CMS QBPAPPEALS
Cc: Moon Leung; Ginette Hawkins; Renee Delphin-Rodriguez
Subject: QBP Reconsideration Form for SCAN Health Plan (H5425)
Date: Friday, November 10, 2023 12:20:11 AM
Attachments: Request_For_Reconsideration_Form_2025 - SCAN Health Plan H5425.xlsm
C1201277_03242023.WAV
Attachment 1. Additional Details To Support QBP Reconsideration v3.docx
Attachment 1. Additional Details To Support QBP Reconsideration.docx

---

Attached please find SCAN Health Plan's Request for Reconsideration for MAPD contract H5425. Please note that in addition to the Excel form, we have attached two additional forms:

- An additional file (.wav format) that includes a recording of a call that we referenced in our justification for reconsideration.
- A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text pasted into the Excel form).

Please let us know if you have any questions.

Also, to ensure CMS receipt of this request for reconsideration, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

Attachment A

Request for Reconsideration

Note: The QBP administrative review process is a two-step process that includes: 1) a request for reconsideration, and 2) a request for an informal hearing after CMS has rendered its reconsideration decision. Both steps are conducted at the contract level. This first step affords an MA organization the opportunity to request a reconsideration of how its Star Rating, for the given measure in question, was calculated. This is not an opportunity for an MA organization to question how every measure was calculated. A request for reconsideration must be submitted by the date and time specified below in order to reserve the right to later request an informal hearing on the record.

Instructions: Use only the "Request for Reconsideration" form that can be found in HPMS. To download a copy of the form from HPMS, select Quality and Performance on the home page, then Performance Metrics. On the Performance Metrics page select Reports, Costs and then MA QBP Rating. One form must be submitted for each contract for which reconsideration is requested. Complete the identifiable information including all contact information. Mark an "X" next to the measure(s) that the MA organization is questioning and requesting reconsideration. In the "Description of the Issue" specify any errors that the MA organization asserts CMS may have made in calculating the contract's QBP determination. Save the information, please include your contract number in the filename and e-mail the completed form along with any additional documentary evidence to be considered to QBPAPPEALS@cms.hhs.gov by the due date.

Due Date: A Request for Reconsideration of QBP is made by completing the Excel version of this form downloaded from HPMS and e-mailing the form to QBPAPPEALS@cms.hhs.gov by 5:00 p.m. EST on November 17, 2023. No late requests will be accepted.

Contract Number (5 character CMS assigned code):	H5425
Contact First Name (your first name):	Michael
Contact Last Name (your last name):	Plumb
Contact Title (your job title):	Chief Financial Officer
Contact Phone Number (your phone number, include extension if necessary):	714-655-9202
Contact email address (your email address):	mplumb@scanhealthplan.com

Overall Rating	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
QBP/Overall Rating	Star Ratings		Not Appealable	

Part C Measures	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
C01-Breast Cancer Screening	HEDIS		Not Appealable	
C02-Colorectal Cancer Screening	HEDIS		Not Appealable	
C03-Annual Flu Vaccine	CAHPS		Not Appealable	
C04-Monitoring Physical Activity	HEDIS / HOS		Not Appealable	
C05-Special Needs Plan (SNP) Care Management	Part C Plan Reporting		Not Appealable	
C06-Care for Older Adults – Medication Review	HEDIS		Not Appealable	
C07-Care for Older Adults – Pain Assessment	HEDIS		Not Appealable	
C08-Osteoporosis Management in Women who had a Fracture	HEDIS		Not Appealable	
C09-Diabetes Care – Eye Exam	HEDIS		Not Appealable	
C10-Diabetes Care – Blood Sugar Controlled	HEDIS		Not Appealable	
C11-Controlling Blood Pressure	HEDIS		Not Appealable	
C12-Reducing the Risk of Falling	HEDIS / HOS		Not Appealable	
C13-Improving Bladder Control	HEDIS / HOS		Not Appealable	
C14-Medication Reconciliation Post-Discharge	HEDIS		Not Appealable	
C15-Plan All-Cause Readmissions	HEDIS		Not Appealable	
C16-Statin Therapy for Patients with Cardiovascular Disease	HEDIS		Not Appealable	
C17-Transitions of Care	HEDIS		Not Appealable	
C18-Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS		Not Appealable	
C19-Getting Needed Care	CAHPS		Not Appealable	
C20-Getting Appointments and Care Quickly	CAHPS		Not Appealable	
C21-Customer Service	CAHPS		Not Appealable	
C22-Rating of Health Care Quality	CAHPS		Not Appealable	
C23-Rating of Health Plan	CAHPS		Not Appealable	
C24-Care Coordination	CAHPS		Not Appealable	
C25-Complaints about the Health Plan	CTM		Not Appealable	
C26-Members Choosing to Leave the Plan	MBDSS		Not Appealable	
C27-Health Plan Quality Improvement	Star Ratings		Not Appealable	
C28-Plan Makes Timely Decisions about Appeals	IRE			
C29-Reviewing Appeals Decisions	IRE			

C30-Call Center – Foreign Language Interpreter and TTY Availability	Call Center		X	We believe incorrect data was used in the calculation for this measure given that one of the foreign language interpreter availability calls (C0600900) is incorrectly included in our results based on a technical issue associated with the non-standard manner in which the CMS caller asked the standard question. Please see the additional comments section below for the explanation.

Part D Measures	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
D01-Call Center – Foreign Language Interpreter and TTY Availability	Call Center			
D02-Complaints about the Drug Plan	CTM	Not Applicable	Not Applicable	Not appealable, use Part C measure C25 above.
D03-Members Choosing to Leave the Plan	MBDSS	Not Applicable	Not Applicable	Not appealable, use Part C measure C26 above.
D04-Drug Plan Quality Improvement	Star Ratings		Not Appealable	
D05-Rating of Drug Plan	CAHPS		Not Appealable	
D06-Getting Needed Prescription Drugs	CAHPS		Not Appealable	
D07-MPF Price Accuracy	PDE, MPF Pricing		Not Appealable	
D08-Medication Adherence for Diabetes Medications	PDE		Not Appealable	
D09-Medication Adherence for Hypertension (RAS antagonists)	PDE		Not Appealable	
D10-Medication Adherence for Cholesterol (Statins)	PDE		Not Appealable	
D11-MTM Program Completion Rate for CMR	Part D Plan Reporting		Not Appealable	
D12-Statin Use in Persons with Diabetes (SUPD)	PDE data		Not Appealable	

Additional Comments (Please provide any additional information relevant to your request)

Request for Reconsideration for Measure C30 – Call Center – Foreign Language Interpreter and TTY Availability based on incorrect data set used to calculate star rating that included call #C0600900 received 2/9/23

For call C0600900, there was a technical issue caused by the CMS caller's deviation from protocol that ultimately caused the call to exceed the 8 minute threshold. The issue was that the CMS caller did not ask the question clearly, including a stumble at the start, and speaking unusually slowly and stating the plan name in a non-standard manner that the interpreter had trouble understanding. The English translation of the CMS caller's question asked was "are you the per……are you the right person to answer questions about the medical advantages of……uhhh…..Village Health…..H-M-O……P-O-S…..C…..S-N-P?" [The dots represent pauses the CMS caller made in speaking] The total time taken to ask the question from beginning to end was 25 seconds, which demonstrates how long the pauses were. The CMS caller's phrasing of the question and the way it was asked, specifically the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. It was the additional 34 second delay caused by the question needing to be repeated that ultimately caused the call to exceed the 8 minute threshold.

For comparison purposes, we have also attached a recording of another French language interpreter availability assessment call that we received this year (C1201277 that we received on 3/24/2023). In call C1201277, the CMS caller asked the same question more clearly without the stumbling and excessively slow spelling out of the plan name (which was the exact same plan name as in call C0600900). The total time taken to ask the question was just 17 seconds and did not result in the interpreter needing to have the question repeated in order to translate. The total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 41 seconds.

For call C0600900, the total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 86 seconds – 45 seconds longer than in call C1201277 where the caller did not stumble through the question and was much clearer. The failed call missed the time cutoff by 31 seconds. Thus, were it not for the additional delay caused by the non-standard way the C0600900 CMS caller asked the question, call C0600900 would have passed and not failed. Additionally, in spite of the 25 seconds it took just to ask the standard question in call C0600900, if you exclude the additional time associated with the question having to be repeated (34 seconds), the call would have been completed within the time limit. The technical specifications for this measure C30 – Call Center – Foreign Language Interpreter and TTY Availability state that "For the interpreter availability measure to be complete, the CSR, with the interpreter's help, must be able to respond "yes" to the introductory question before the 8-minute timer expires." Time delays that are caused by the CMS caller asking the question in a non-standard way, and thus causing confusion on the part of the interpreter and the need for the call to be repeated, should not be included in the evaluation of a specific call success. Thus, we believe that this call was incorrectly included as a failure in our data and should be reversed to be counted as a completed call since the time in excess of 8 minutes was due to the CMS's caller's failure to follow established CMS protocols. At a minimum, the non-standard way the question was asked should warrant exclusion of this call from the dataset for this measure. CMS mischaracterized the call as a failure, and this data inaccuracy led to a calculation error for our performance on the C30 measure.

Additional Note
It is also worth noting that another possible contributor to the problem with call C0600900 was a technical issue with the standard question asked – specifically, that the question asked was not consistent with the standard question outlined in the Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes. Page 17 of the technical notes state that the introductory question asked by CMS callers is "are you the right person to answer questions about [Plan name's] health benefits?" However, in call C0600900, the CMS caller framed the question in a way different than what is identified in the technical notes. The caller asked "are you the right person to answer questions about the medical advantages of [Plan name]." When dealing with Medicare Advantage products, asking the question with "medical advantages" right before the Plan name can cause additional confusion for the interpreter, and was a proximate cause of call C0600900 exceeding the 8 minute time limit. Where a deviation from the published CMS protocols by CMS or its contractor is the cause of an MA plan exceeding the 8 minute threshold, it is not appropriate for CMS to penalize the MA plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1129 and form number CMS-10346 (Expires: 8/31/2024). The time required to complete this information collection is estimated to average 8 hours, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

Request for Reconsideration for Measure C30 – Call Center – Foreign Language Interpreter and TTY Availability based on incorrect data set used to calculate star rating that included call #C0600900 received 2/9/23

For call C0600900, there was a technical issue caused by the CMS caller's deviation from protocol that ultimately caused the call to exceed the 8 minute threshold. The issue was that the CMS caller did not ask the question clearly, including a stumble at the start, and speaking unusually slowly and stating the plan name in a non-standard manner that the interpreter had trouble understanding. The English translation of the CMS caller's question asked was "are you the per……are you the right person to answer questions about the medical advantages of……uhhh…..Village Health…..H-M-O……P-O-S…..C…..S-N-P?" [The dots represent pauses the CMS caller made in speaking] The total time taken to ask the question from beginning to end was 25 seconds, which demonstrates how long the pauses were. The CMS caller's phrasing of the question and the way it was asked, specifically the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. It was the additional 34 second delay caused by the question needing to be repeated that ultimately caused the call to exceed the 8 minute threshold.

For comparison purposes, we have also attached a recording of another French language interpreter availability assessment call that we received this year (C1201277 that we received on 3/24/2023). In call C1201277, the CMS caller asked the same question more clearly without the stumbling and excessively slow spelling out of the plan name (which was the exact same plan name as in call C0600900). The total time taken to ask the question was just 17 seconds and did not result in the interpreter needing to have the question repeated in order to translate. The total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 41 seconds.

For call C0600900, the total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 86 seconds – 45 seconds longer than in call C1201277 where the caller did not stumble through the question and was much clearer. The failed call missed the time cutoff by 31 seconds. Thus, were it not for the additional delay caused by the non-standard way the C0600900 CMS caller asked the question, call C0600900 would have passed and not failed. Additionally, in spite of the 25 seconds it took just to ask the standard question in call C0600900, if you exclude the additional time associated with the question having to be repeated (34 seconds), the call would have been completed within the time limit. The technical specifications for this measure C30 – Call Center – Foreign Language Interpreter and TTY Availability state that "For the interpreter availability measure to be complete, the CSR, with the interpreter's help, must be able to respond "yes" to the introductory question before the 8-minute timer expires." Time delays that are caused by the CMS caller asking the question in a non-standard way, and thus causing confusion on the part of the interpreter and the need for the call to be repeated, should not be included in the evaluation of a specific call success. Thus, we believe that this call was incorrectly included as a failure in our data and should be reversed to be counted as a completed call since the time in excess of 8 minutes was due to the CMS's caller's failure to follow established CMS protocols. At a minimum, the non-standard way the question was asked should warrant exclusion of this call from the dataset for this measure. CMS mischaracterized the call as a failure, and this data inaccuracy led to a calculation error for our performance on the C30 measure.

<u>Additional Note</u>
It is also worth noting that another possible contributor to the problem with call C0600900 was a technical issue with the standard question asked – specifically, that the question asked was not consistent with the standard question outlined in the Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes. Page 17 of the technical notes state that the introductory question asked by CMS callers is "are you the right person to answer questions about

[Plan name's] health benefits?" However, in call C0600900, the CMS caller framed the question in a way different than what is identified in the technical notes. The caller asked "are you the right person to answer questions about the medical advantages of [Plan name]." When dealing with Medicare Advantage products, asking the question with "medical advantages" right before the Plan name can cause additional confusion for the interpreter, and was a proximate cause of call C0600900 exceeding the 8 minute time limit. Where a deviation from the published CMS protocols by CMS or its contractor is the cause of an MA plan exceeding the 8 minute threshold, it is not appropriate for CMS to penalize the MA plan.

TAB 27

From:	Jody Dougherty
To:	Bottiani, Gregory (CMS/CM); Stoyer, Stephen (CMS/CM); Spaccarelli (she/her), Arianne (CMS/CM); CMS CallCenterMonitoring; "Walter, Kelsey"
Subject:	RE: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)
Date:	Thursday, February 1, 2024 1:47:49 PM
Attachments:	Transcript of French Call C0600900 updated.docx

The updated translation is attached – please let us know if you have any questions.

Thanks,
Jody

From: Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>
Sent: Thursday, February 1, 2024 11:39 AM
To: Jody Dougherty <jody.dougherty@hendall.com>; Stoyer, Stephen (CMS/CM) <Stephen.Stoyer@cms.hhs.gov>; Spaccarelli (she/her), Arianne (CMS/CM) <Arianne.Spaccarelli@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; 'Walter, Kelsey' <kwalter@air.org>
Subject: RE: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

Sorry to do this to you and Colin, but I have comments in the attached. Specifically, the plan has argued that the caller was not clear and that is why the interpreter asked for the question to be repeated. If the interpreter admitted to not taking notes and that is why they didn't catch the full question, it is very important, and we need that in the transcript. It is also important that we have exactly what was said throughout the entirety of the call and translated to English when said in French. Thanks again for your work on this. We do need it back A.S.A.P.

From: Jody Dougherty <jody.dougherty@hendall.com>
Sent: Thursday, February 1, 2024 11:01 AM
To: Stoyer, Stephen (CMS/CM) <Stephen.Stoyer@cms.hhs.gov>; Spaccarelli (she/her), Arianne (CMS/CM) <Arianne.Spaccarelli@cms.hhs.gov>; Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; 'Walter, Kelsey' <kwalter@air.org>
Subject: RE: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

Colin's translation is attached and here are his summary notes:

> After listening to the whole call, the French interviewer was on hold for a long period of time. I did hear the CSR come back on the line and say in English that he was still trying to locate a translator. When the interpreter came on the line, once the interpreter addressed the interviewer and gave her his greeting, the interviewer greeted the interpreter and then read the opening question verbatim. After she read the opening question, the interpreter said in French that he failed to take notes and asked her to repeat the end of the question, which she did and said the plan name clearly so the interpreter could accurately interpret it. The interpreter gave a pretty accurate rendition of the call in English, saying "Village Plus" instead of "Village Health". The interpreter did give the CSR's yes to the interviewer, and

then the interviewer read the timeout script.

From: Stoyer, Stephen (CMS/CM) <Stephen.Stoyer@cms.hhs.gov>
Sent: Tuesday, January 30, 2024 1:03 PM
To: Jody Dougherty <jody.dougherty@hendall.com>; Spaccarelli (she/her), Arianne (CMS/CM) <Arianne.Spaccarelli@cms.hhs.gov>; Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; 'Walter, Kelsey' <kwalter@air.org>
Subject: RE: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

Hi Jody,

Could you have Colin perform the same task for the attached recording. It appears that the first recording we sent over that was provided by SCAN is for a different call. I hate to ask for a quick turnaround but we need this as soon as possible.

Thank you!

From: Jody Dougherty <jody.dougherty@hendall.com>
Sent: Tuesday, January 30, 2024 10:04 AM
To: Spaccarelli (she/her), Arianne (CMS/CM) <Arianne.Spaccarelli@cms.hhs.gov>; Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; 'Walter, Kelsey' <kwalter@air.org>
Cc: Stoyer, Stephen (CMS/CM) <Stephen.Stoyer@cms.hhs.gov>
Subject: RE: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

Good morning,

Attached is a word document with the transcript of the call – and Colin also passed along this note as well:

> After listening to the whole call, it appears that the interpreter that the plan conferenced in didn't interpret the question accurately. Also, there was no hesitation or stopping and starting on the French interviewer's end. I clearly heard our interviewer say in French, "Are you the right person, etc." clearly and with no hesitation. The interpreter left out some parts of the question, including the word "questions" and she mispronounced the plan name. It's hard to understand what the interpreter thought the plan name was, it sounded like "this low plan" and not "Village Health".

Just a reminder, Colin (from AIR) is fluent in French and has worked on the CCM project as long as I can remember – at least 5 but probably closer to 10 years. He has been the primary trainer for both surveys during his time on the project, in addition to the supervision and management of the callers. He knows the project quite well and the process callers must follow for both English and Language/TTY calls.

Let us know if you have any questions.
Thank you,
Jody

From: Spaccarelli (she/her), Arianne (CMS/CM) <Arianne.Spaccarelli@cms.hhs.gov>
Sent: Monday, January 29, 2024 3:43 PM
To: Jody Dougherty <jody.dougherty@hendall.com>; Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; 'Walter, Kelsey' <kwalter@air.org>
Cc: Stoyer, Stephen (CMS/CM) <Stephen.Stoyer@cms.hhs.gov>
Subject: RE: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

Thank you!

From: Jody Dougherty <jody.dougherty@hendall.com>
Sent: Monday, January 29, 2024 2:15 PM
To: Spaccarelli (she/her), Arianne (CMS/CM) <Arianne.Spaccarelli@cms.hhs.gov>; Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; 'Walter, Kelsey' <kwalter@air.org>
Cc: Stoyer, Stephen (CMS/CM) <Stephen.Stoyer@cms.hhs.gov>
Subject: RE: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

I wanted to give you an update – Colin, our French speaker will translate the entire conversation from the recording in between the trainings he's leading today. We should have it by tomorrow. He did confirm that "des" in all the questions should be "les". I've noted that in the table below.

Item #	Request	Response
1	Standard version of the question when asked in English	Are you the right person to answer questions about [Plan name's] health benefits?
2	The standard version of the question from our guidance in French	Etes-vous la personne adéquate pour répondre aux questions concernant ~~des~~ les avantages médicaux de [Plan name]?
3	The standard version of the question translated to English	Are you the right person to answer questions about health benefits of [Plan name]?
4	Exactly what the interviewer actually asked in French	Bonjour. Etes-vous la personne adéquate pour répondre aux questions concernant ~~des~~ les avantages

		médicaux de Village Health HMO POS D-SNP?
5	Exactly what the interviewer actually asked translated to English	Hello. Are you the right person to answer questions about health benefits of Village Health HMO POS D-SNP?
6	What SCAN claims the interviewer asked in French	Etes-vous la personne adéquate pour répondre aux questions concernant ~~des~~ les avantages médicaux de [Plan name]?
7	What SCAN claims the interviewer asked translated to English	Are you the right person to answer questions about the medical advantages of [Plan name]?

Thank you,
Jody

From: Spaccarelli (she/her), Arianne (CMS/CM) <Arianne.Spaccarelli@cms.hhs.gov>
Sent: Friday, January 26, 2024 4:25 PM
To: Jody Dougherty <jody.dougherty@hendall.com>; Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; 'Walter, Kelsey' <kwalter@air.org>
Cc: Stoyer, Stephen (CMS/CM) <Stephen.Stoyer@cms.hhs.gov>
Subject: RE: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

It would be helpful for him to listen again. I know this has gone back and forth a number of times, so I appreciate it!

It's a question from CMS in preparing the response to the plan's appeal. Your French speaking staffer's input is VERY helpful.

From: Jody Dougherty <jody.dougherty@hendall.com>
Sent: Friday, January 26, 2024 4:18 PM
To: Spaccarelli (she/her), Arianne (CMS/CM) <Arianne.Spaccarelli@cms.hhs.gov>; Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; 'Walter, Kelsey' <kwalter@air.org>
Cc: Stoyer, Stephen (CMS/CM) <Stephen.Stoyer@cms.hhs.gov>
Subject: RE: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

Our expert French/CCM person is actually tied up conducting training so we can't confirm that right now, but we will have him look at it as soon as possible.

Since it's a short call, would it be helpful to have us translate it completely so to note where the

verbal stumbling is coming from? Based on our listening to this call, we still believe it was done correctly by the caller. So, it's more a translation issue or question from the plan?

Thanks,
Jody

From: Spaccarelli (she/her), Arianne (CMS/CM) <Arianne.Spaccarelli@cms.hhs.gov>
Sent: Friday, January 26, 2024 3:42 PM
To: Jody Dougherty <jody.dougherty@hendall.com>; Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; 'Walter, Kelsey' <kwalter@air.org>
Cc: Stoyer, Stephen (CMS/CM) <Stephen.Stoyer@cms.hhs.gov>
Subject: RE: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

Thanks, Jody. Should the "des" in row 4 be "les" as well? And should there be a "the" before "health benefits" in Row 5?

Also, do you know where the "uhh" and false start of "Are you the per . . ." came from in the English translation in row 7? I'm not sure if it's something SCAN said when translating it to us or if they were attempting to repeat some verbal stumbling from the original French speaking caller.

From: Jody Dougherty <jody.dougherty@hendall.com>
Sent: Friday, January 26, 2024 1:50 PM
To: Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; 'Walter, Kelsey' <kwalter@air.org>
Cc: Stoyer, Stephen (CMS/CM) <Stephen.Stoyer@cms.hhs.gov>; Spaccarelli (she/her), Arianne (CMS/CM) <Arianne.Spaccarelli@cms.hhs.gov>
Subject: RE: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

Good afternoon,

First, the table below has a typo in number 6. The "des" should be "les". I've put strikethrough the wrong word and added the correct one in red font. There is a fluent French speaker on the AIR team who has also worked on the CCM project for at least 5, if not closer to 10 years. He knows the project very well, and the French language. He listened to the recording and can confirm that he heard "les", and "les" is correct and what is in 6 below is correct. He reviewed this question further and offered up some helpful explanations that we wanted to share:

The translation of the question "Êtes-vous la personne adéquate pour répondre aux questions concernant les avantages médicaux de [Plan name]?" is, "Are you the right person to answer questions about [Plan name's] **health benefits**?"

He further explained that a person might translate this to say, "Are you the right person to answer questions about the **medical advantages of** [Plan name]?", which is what Google translate will translate it to say in English. However, if someone translates the question this way, they are not

taking into account the context of the question, which is related to a health plan/health benefits. It's a bit nuanced, and a good translator/fluent French speaker would recognize the context for this question and understand that they should say "Are you the right person to answer questions about [Plan name's] health benefits?"

There isn't a better way to translate the question to clarify the potential confusion here.

We feel that using an English-French dictionary would not be helpful in clarifying this but rather if some sort of affidavit or attestation is needed to confirm translations we suggest we reach out to our translation language services company to see if they are able and willing to provide something like that for us.

I think it's important to note that most, if not all, languages have some minor variations due to different dialects and skill/knowledge of translators.

Please let us know if you have further questions.
Thanks,
Jody

From: Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>
Sent: Thursday, January 25, 2024 5:02 PM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; Jody Dougherty <jody.dougherty@hendall.com>; 'Walter, Kelsey' <kwalter@air.org>
Cc: Stoyer, Stephen (CMS/CM) <Stephen.Stoyer@cms.hhs.gov>; Spaccarelli (she/her), Arianne (CMS/CM) <Arianne.Spaccarelli@cms.hhs.gov>
Subject: RE: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

Hi Jody…Stave and I are both out of the office tomorrow so wanted to ask you to ensure that you reply to all if the response is ready before Monday. Thanks, and have a great weekend!

From: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Sent: Thursday, January 25, 2024 11:32 AM
To: Jody Dougherty <jody.dougherty@hendall.com>; Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>; 'Walter, Kelsey' <kwalter@air.org>
Cc: Stoyer, Stephen (CMS/CM) <Stephen.Stoyer@cms.hhs.gov>; Spaccarelli (she/her), Arianne (CMS/CM) <Arianne.Spaccarelli@cms.hhs.gov>
Subject: RE: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

HI Jody, we have a couple follow up questions.

Can you confirm that you translated number 6 from the table below based on what was in 7? If the answer is yes, please translate this language into French.

"Are you the per……are you the right person to answer questions about the medical advantages of……uhhh…..Village Health…..H-M-O……P-O-S…..C…..S-N-P?"

Can we back up the statement that CMS's French translation of the standard question is correct? OGC is wondering if we could use an English-French dictionary or an affidavit from a French/English speaker? We don't actually need to do this right now but need to know if we could if needed in the future.

Thanks!

Steve

From: Jody Dougherty <jody.dougherty@hendall.com>
Sent: Friday, January 19, 2024 8:25 PM
To: Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>; 'Walter, Kelsey' <kwalter@air.org>
Cc: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; Stoyer, Stephen (CMS/CM) <Stephen.Stoyer@cms.hhs.gov>; Spaccarelli (she/her), Arianne (CMS/CM) <Arianne.Spaccarelli@cms.hhs.gov>
Subject: RE: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

Greg,

The AIR staff have updated the response column in the table below. Please let us know if you have any questions.

Thanks,
Jody

Item #	Request	Response
1	Standard version of the question when asked in English	Are you the right person to answer questions about [Plan name's] health benefits?
2	The standard version of the question from our guidance in French	Etes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de [Plan name]?
3	The standard version of the question translated to English	Are you the right person to answer questions about health benefits of [Plan name]?
4	Exactly what the interviewer actually asked in French	Bonjour. Etes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de Village Health HMO POS D-SNP?
5	Exactly what the interviewer actually asked	Hello. Are you the right person to

	translated to English	answer questions about health benefits of Village Health HMO POS D-SNP?
6	What SCAN claims the interviewer asked in French	Etes-vous la personne adéquate pour répondre aux questions concernant ~~des~~ les avantages médicaux de [Plan name]?
7	What SCAN claims the interviewer asked translated to English	Are you the right person to answer questions about the medical advantages of [Plan name]?

From: Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>
Sent: Friday, January 19, 2024 4:15 PM
To: Jody Dougherty <jody.dougherty@hendall.com>; 'Walter, Kelsey' <kwalter@air.org>
Cc: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; Stoyer, Stephen (CMS/CM) <Stephen.Stoyer@cms.hhs.gov>; Spaccarelli (she/her), Arianne (CMS/CM) <Arianne.Spaccarelli@cms.hhs.gov>
Subject: [External Sender] FW: QBP Reconsideration Form for SCAN Health Plan (H5425)
Importance: High

Good afternoon,

Hoping you can assist with a request from the folks handling this appeal by completing the table no later than COB Monday. Let us know if you have any questions or concerns, or need additional information.

Thanks, and have a great weekend.

Item #	Request	Response
1	Standard version of the question when asked in English	Are you the right person to answer questions about [Plan name's] health benefits?
2	The standard version of the question from our guidance in French	
3	The standard version of the question translated to English	
4	Exactly what the interviewer actually asked in French	
5	Exactly what the interviewer actually asked translated to English	
6	What SCAN claims the interviewer asked in French	

7	What SCAN claims the interviewer asked translated to English	Are you the right person to answer questions about the medical advantages of [Plan name].

From: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Sent: Tuesday, November 14, 2023 3:10 PM
To: Anders (she/her), Linda (CMS/CM) <Linda.Anders@cms.hhs.gov>
Cc: Casey, Kerry (CMS/CM) <Kerry.Casey1@cms.hhs.gov>; Bottiani, Gregory (CMS/CM) <gregory.bottiani@cms.hhs.gov>
Subject: FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

In case you want to listen to the recording of the SCAN French call in question.

From: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Sent: Monday, November 13, 2023 12:35 PM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Gaillot, Sarah (CMS/CM) <Sarah.Gaillot@cms.hhs.gov>; Goldstein, Elizabeth (CMS/CM) <Elizabeth.Goldstein@cms.hhs.gov>
Subject: FW: QBP Reconsideration Form for SCAN Health Plan (H5425)

Hi Steve,

This one plays for me. Can you see if it plays for you?

-Joy-

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Monday, November 13, 2023 12:31 PM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

Also strange – maybe there was an issue when attaching multiple files to the original email. I have attached the WAV file again here. Will it play for you this time?

From: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Sent: Monday, November 13, 2023 8:52 AM
To: Michael Plumb <MPlumb@scanhealthplan.com>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

Thank you Michael! This works now. I was able to open the excel file and the word files. The WAV file opens but nothing is playing for us.

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Monday, November 13, 2023 11:36 AM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

That's strange – we downloaded it from the HPMS website. Thank you for letting us know. I have attached it again, please let me know if you continue to have a problem opening the excel spreadsheet.

Were you able to open the additional files attached to our e-mail (Microsoft Word file and .WAV file)?

From: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Sent: Monday, November 13, 2023 5:07 AM
To: Michael Plumb <MPlumb@scanhealthplan.com>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

Hi Michael,

We are unable to open the excel spreadsheet. Can you please resend?

QBP Appeals Team

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Friday, November 10, 2023 12:14 AM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: QBP Reconsideration Form for SCAN Health Plan (H5425)

Attached please find SCAN Health Plan's Request for Reconsideration for MAPD contract H5425. Please note that in addition to the Excel form, we have attached two additional forms:

- An additional file (.wav format) that includes a recording of a call that we referenced in our

justification for reconsideration.
- A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text pasted into the Excel form).

Please let us know if you have any questions.

Also, to ensure CMS receipt of this request for reconsideration, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential

and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

Transcript of French Call

Scan Health Plan CSR: Thank you for calling Scan Health plan, this is [CSR name], who do I have the pleasure of speaking with?

Interviewer: Uh, French, I need French.

CSR: Yes of course, one moment please.

(Hold queue music.)

CSR: One moment please, I'm still trying to locate a translator.

(Hold queue music.)

Interpreter: [hard to hear] your interpreter, everything you say will remain secret and confidential.

CSR (overlapping): Yes thank you.

Interpreter: How may I help you?

CSR: I have someone on the line who speaks French, please go ahead.

Interpreter: Bonjour, je m'appelle [name of interpreter], je suis votre interprète de français, tout ce qui vous allez dire va rester secret et confidentiel.

(Translated into English): Hello, my name is [name of interpreter], I am your French interpreter, all that you are going to say will stay secret and confidential.

Interviewer : Oui, bonsoir, alors j'ai, j'ai une question –

(Translated into English): Yes, good evening, so I, I have a question -

Interpreter (overlapping): Bonsoir.

(Translated into English): Good evening.

Interviewer: Êtes-vous la…êtes-vous la personne adéquate pour répondre aux questions concernant les avantages médicaux de Village Health HMO-POS C-SNP ?

(Translated into English): Are you the…are you the right person to answer questions about health benefits of Village Health HMO-POS C-SNP?

Interpreter: Excusez, madame, j'ai…j'ai raté de prendre notes. Les avantages médicaux de Village, s'il vous plaît, si vous pourrez répéter ?

(Translated into English): Excuse me, ma'am, I…I failed to take notes. Health benefits of Village, if you will repeat please?

Interviewer: Oui, c'est le nom du plan. C'est Village Health, ensuite HMO-POS C-SNP.

(Translated into English): Yes, it's the name of the plan. It's Village Health, then HMO-POS C-SNP.

Interpreter: Are you the right person to answer questions about the plan Village Plus HMO-POS C-SNP?

CSR: Yes, of course, how may I assist you?

Interpreter: Bien sûr, qu'est-ce que je peux faire pour vous ?

(Translated into English): Of course, what can I do for you?

Interviewer: Thank you, this has been a test call for the Centers for Medicare and Medicaid Services. We have reached the time limit for this question. Have a good day.

CSR: Thank you, you too. Thank you, interpreter.

Interviewer (overlapping): Mm hmm.

Interpreter: Interpreter 069754 disconnecting, thank you for using our, our services.