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March 5, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for the Medicare Advantage CMS-HCC Risk Adjustment Model and Advance Notice of Methodological Changes for CY 2019 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2019 Draft Call Letter

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinical partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) 2019 Advance Notice and draft Call Letter for 2019. The Advance Notice was released in two parts: one on Dec. 27, 2017 and the other on Feb. 1. Our comment letter responds to proposals in both Parts I and II.

The notice presents several policy proposals, as well as potential operational and technical modifications, to the requirements for health plans under the Medicare Advantage (MA) and Part D prescription drug benefit programs for 2019. As such, the notice and call letter addresses several areas of importance to hospitals and health systems, especially those that offer MA and Part D plans. In fact, approximately 80 AHA members sponsor health plans. **The AHA supports CMS's proposals to expand the types of supplemental benefits that MA plans could offer to better manage beneficiary health. We also generally support CMS's proposals that would allow plans to better prevent opioid misuse and addiction. However, we continue to remain concerned about increasing the use of encounter data for purposes of risk adjustment.** Our detailed comments follow.



PROVISIONS IN PART I OF THE ADVANCE NOTICE

Encounter Data. CMS proposes to change the current methodology for calculating risk scores by increasing the percentage of the blended score that is based on encounter data. Specifically, CMS proposes to increase the amount of the risk score that is calculated using encounter data to 25 percent, up from 15 percent. **The AHA continues to have strong reservations about relying on encounter data to calculate risk scores at this time.**

We remain concerned that the use of encounter data may result in inaccurate risk scores. Specifically, provider data collection efforts were not designed to support MA risk-adjustment calculations. In our previous [comments to the agency](#) we provided examples of the types of technological and coding limitations and discuss whether CMS has done enough to address the data quality problems identified by the Government Accountability Office (GAO).¹ **We encourage CMS to reconsider the use of encounter data until the issues related to data quality, and provider and plan burden are addressed.**

All Condition Count vs. Payment Condition Count. CMS identifies two different approaches to account for a beneficiary's multiple conditions in the risk model. Under the All Condition Count approach, CMS would take into account all conditions that a beneficiary has, including conditions that are included in the payment model and those that are not. Under the Payment Condition Count approach, CMS would take into account only those conditions that are included in the payment model. **CMS proposes to use the Payment Condition Count approach, and we agree.** We believe, consistent with CMS's analysis, that this model would better compensate MA plans for the real risk associated with beneficiaries, as well as reduce variation among plan contracts.

PROVISIONS IN PART II OF THE ADVANCE NOTICE

Supplemental Benefits. CMS proposes a new interpretation of federal law that would allow MA plans to provide additional supplemental benefits if those benefits meet certain criteria, such as compensating for physical impairments, diminishing the impact of injuries or health conditions, or reducing avoidable health care utilization. **The AHA strongly supports this proposal.**

The vast majority of health and healing is a result of what happens within an individual's home and community, and is facilitated by non-medical social supports. For example, many Medicare beneficiaries need some assistance with basic daily tasks, including taking medications and eating healthfully, as well as modifying their homes to avoid injury. Many of the services that enable individuals to heal and stay healthy within their communities are not consider medical services and have, therefore, not been as widely available through the MA program. This proposal, as well as recent changes to the Social Security Act through the Bipartisan Budget Act of 2018, will better enable MA plans and their network providers to ensure that Medicare

¹ Government Accountability Office, "Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments," January 2017.

beneficiaries have a more comprehensive complement of services to help them manage their health.

Part D: Provisions Related to Opioid Misuse Prevention & Identification. CMS proposes several changes to help prevent opioid overuse, including establishing expectations for hard safety edits at the point of sale, implementing fill limits, and adding new reporting requirements, among other changes. The AHA appreciates the attention on this issue and generally supports these efforts. **Specifically, we generally support CMS's proposal to ask health plans to report whether there is concurrent prescribing of opioids and benzodiazepines. However, we urge CMS to consider focusing the measure on new concurrent prescriptions, rather than all prescriptions.**

We agree that in nearly all cases, the concurrent prescribing of opioids and benzodiazepines presents significant risk. However, some patients may arrive at a facility already on a prescription for a benzodiazepine. Patients may need to be weaned of the benzodiazepine, so terminating the prescription immediately can result in serious harm to the patient. Thus, rather than simply measuring the existence of concurrent prescriptions, CMS could consider modifying the measure to evaluate new prescriptions where both types of drugs were simultaneously prescribed.

We also encourage the agency to reevaluate its position related to coverage of certain services to help Medicare beneficiaries treat opioid use disorder. **For example, we encourage CMS to extend coverage to outpatient medication-assisted treatment.** Such therapies are critical for helping those beneficiaries who are experiencing addiction obtain the help they need to recover.

Thank you for the opportunity to comment. Please contact me if you have questions or feel free to have a member of your team contact Molly Smith, senior associate director of policy, at (202) 626-4639 or mollysmith@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President
Government Relations and Public Policy