

March 1, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for comments on the Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) CMS–HCC Risk Adjustment Model and the Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) December 20, 2018 "Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for the Medicare Advantage (MA) CMS–HCC Risk Adjustment Model" and the January 30, 2019 "Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter." We appreciate your staff's work on the notice, particularly considering the statutory requirements for extensive changes to the risk adjustment model.

Our comments focus on the following issues:

- Part C risk adjustment model changes required by the 21st Century Cures Act:
 - Using at least 2 years of diagnostic data
 - Proposed and alternative payment condition count (PCC) models
- Encounter data and Risk Adjustment Processing System (RAPS) data as a source of diagnoses for 2020
- Additional uses of encounter data:
 - Potential changes to existing star rating and display measures
 - Medicare Advantage organizations crossing claims over to Medicaid agencies
- Dual-eligible special needs plan (D–SNP) "look-alikes"

Using at least two years of diagnostic data

Medicare payments to MA plans are enrollee specific and account for differences in health status by applying a risk score that, relative to a base payment amount, increases payments for

beneficiaries with higher expected medical expenditures and decreases payments for beneficiaries with lower expected medical expenditures. The risk adjustment model (known as the CMS-hierarchical condition category (CMS-HCC) model) uses demographic information along with diagnostic information from the calendar year prior to the payment year to calculate a coefficient for each demographic characteristic and medical condition in the model. Demographic characteristics and medical conditions with larger coefficients are associated with higher expected medical expenditures and vice versa. A risk score is the sum of the coefficients identified for a beneficiary.

CMS estimates the size of the coefficients with spending and diagnostic data from fee-for-service (FFS) claims, which are the only available data source with complete spending and diagnostic data. To calculate risk scores for MA enrollees, CMS applies the coefficients estimated with FFS data to demographic and diagnostic information for MA enrollees. Therefore, the completeness and accuracy of diagnostic data in both FFS Medicare and MA affect the accuracy of risk scores and payments to MA plans. CMS currently uses one year of diagnostic data to estimate the size of the coefficients with FFS data and to identify diagnoses for MA enrollees.

The 21st Century Cures Act mandates certain updates to the MA risk adjustment model and permits the Secretary to use at least two years of diagnostic data in the calculation of the risk adjustment model. CMS addresses the required risk adjustment provisions of the 21st Century Cures Act in the advance notice, noting that updates to the risk adjustment model must be initiated in 2020 to meet the timeline mandated by the Act. CMS did not propose to use two years of FFS and MA diagnostic data to estimate the model and calculate MA risk scores.

Comment

CMS should use two years of diagnostic data for risk adjustment for future years. In a 2000 mandated report to the Congress (prior to the implementation of the CMS-HCC model), the Commission recommended that CMS use more than one year of diagnostic data as a way to make payments more accurate and payments to plans more stable over time.¹ Subsequent research by MedPAC and others shows that in both FFS Medicare and MA, some beneficiaries who have a chronic condition (a condition that persists over time and is expected to be documented every year after diagnosis) identified in one year do not have the condition identified in the subsequent year.^{2,3} Such inconsistencies in FFS diagnostic data reduce the accuracy of the model coefficients, while inconsistencies in MA diagnostic data introduce year-to-year fluctuations in MA enrollee risk scores and the resulting payments to MA plans. Using two years of diagnostic data would both improve the accuracy of coefficients estimated with FFS data and reduce year-to-year variation in payments to MA plans.

¹ Medicare Payment Advisory Commission. 2000. *Report to the Congress: Improving risk adjustment in Medicare*. Washington, DC: MedPAC.

² Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

³ Frogner, B. K., G. F. Anderson, R. A. Cohen, et al. 2011. Incorporating new research into Medicare risk adjustment. *Medical Care* 49, no. 3 (March): 295–300.

In 2016, the Commission recommended that CMS use two years of diagnostic data for risk adjustment.⁴ MedPAC's prior analysis of chronic coding persistence also shows that having a chronic condition coded in one year and not in the subsequent year occurred more often for FFS beneficiaries than MA beneficiaries.⁵ A separate MedPAC analysis shows that these differential coding rates between MA and FFS Medicare cause Medicare payments to MA plans to be higher than they would have been had the MA enrollees been enrolled in FFS Medicare instead.^{6,7} Therefore, the improvement to FFS diagnostic data from using two years of diagnostic data would reduce the difference in coding rates between MA and FFS Medicare and improve the accuracy of payments to MA plans.

Proposed Payment Condition Count model and alternative model

The 21st Century Cures Act requires the Secretary to modify the CMS–HCC risk adjustment model to reflect not only beneficiaries' medical conditions, but also the number of those conditions. CMS proposes to add a count of the number of conditions for each beneficiary, based on the HCCs used for payment (i.e., those included in the risk adjustment model). Some medical conditions are represented by HCCs that are not included in the risk adjustment model and are therefore not used for payment. The count variables would be added to the version of the CMS–HCC model used in 2019, which incorporated other provisions of the 21st Century Cures Act (adding HCCs for mental health, substance abuse, and chronic kidney disease). The resulting version of the CMS–HCC model is called the Payment Condition Count (PCC) model.

The advance notice presents for consideration an alternative CMS–HCC model that builds on the proposed PCC model by adding two HCCs for dementia and one HCC for pressure ulcers. This alternative is based on CMS's review of the HCCs not currently included in the risk adjustment model. CMS identified HCCs not in the model for which there are 30,000 or more beneficiaries who have the condition and for whom the model performs less well (having an average predictive ratio below 0.9, where 1.0 represents perfect prediction of spending). CMS considered certain risk adjustment principles in evaluating whether the identified HCCs (1) are well-specified (clinically meaningful), (2) predict medical expenditures, and (3) are definitively diagnosed (do not comprise discretionary diagnoses). CMS concludes that three HCCs abide by the principles: dementia with complications, dementia without complications, and pressure ulcer of skin with partial thickness skin loss.

Comment

The Commission supports the proposal to implement the PCC model in 2020. Over the last two advance notices, CMS has carefully considered which conditions to count and how to implement a set of count variables that improves prediction for certain groups of beneficiaries and adheres to

⁴ Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

⁵ MedPAC 2012.

⁶ MedPAC 2016.

⁷ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

the principles of risk adjustment. Our own analysis of this issue concludes that adding a count of conditions improves the accuracy of the risk adjustment model for beneficiaries who have many conditions.⁸ We believe the proposed PCC model accomplishes these goals to the greatest extent relative to the alternatives considered.

The Commission has concerns about the alternative model, specifically the inclusion of HCCs for dementia. In this advance notice, CMS claims that the two dementia HCCs are well-specified and are definitively diagnosed, which contradicts CMS's conclusion in the advance notice for 2014 that "due to concerns about the specificity of coding, dementia HCCs are not included in the 2014 model."⁹ CMS should explain why its conclusion about dementia HCCs has changed. Setting aside this significant concern, we commend CMS on efforts to improve the risk adjustment model based on rigorous evaluation of available HCCs.

Encounter data and RAPS data as a source of diagnoses for 2020

Medicare payments to MA plans are enrollee specific and account for differences in health status by applying a risk score to a base payment rate (described more thoroughly on pp. 1–2 of this letter). For 2020, CMS proposes to use two versions of the CMS–HCC risk adjustment model that will each generate a risk score. The two risk scores will be blended with equal weight (50 percent each) into a single risk score used for payment.

Since the implementation of the CMS–HCC model in 2004, CMS has collected through RAPS the minimum information needed for risk adjustment, including beneficiary ID, date of encounter, type of provider, and diagnosis code. In 2012, CMS began collecting a more complete set of data about each health care encounter for MA enrollees. Encounter data include a similar set of elements as FFS claims data, including more specific data elements (e.g., specific provider information, services provided, payment amounts for most services). For 2020, CMS proposes to use the following combination of risk adjustment models and diagnostic data sources:

- The PCC model, the version of the CMS–HCC model that incorporates changes required by the 21st Century Cures Act, will use encounter data pooled with inpatient RAPS data as the source of diagnoses. In last year's advance notice, CMS found the number of inpatient records reported in encounter data to be low relative to inpatient records reported in RAPS data and therefore proposed pooling inpatient RAPS data with encounter data.
- The version of the CMS–HCC model introduced in 2017 will use RAPS data as the sole source of diagnoses.

CMS also described a schedule mandated by the 21st Century Cures Act that would phase in the PCC model over a three-year period with 100 percent of MA payments based on that model for 2022. If the proposal is implemented, 2020 would be the second year that CMS uses encounter

⁸ MedPAC 2012.

⁹ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013. Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter. February 15.

data as the source of diagnoses for the model incorporating changes mandated by the Act (the proposed PCC model for 2020) and subject to the Act's phase-in schedule from 2020 to 2022. CMS did not specifically state that encounter data would continue to be the source of diagnoses for the PCC model for the duration of the phase-in period.

Comment

We have significant concerns about the overall accuracy of RAPS data and its continued use for risk adjustment. RAPS data have received relatively little scrutiny. Initial results from the few audits of RAPS data that have been completed reveal a large number of diagnoses reported in RAPS data that are not supported by medical records as required by risk adjustment rules.¹⁰ Furthermore, CMS believes that forthcoming audits of RAPS data (audits have not yet begun for payment years relying on encounter data) have generated a “sentinel effect” for plans to ensure that their RAPS data can be verified during an audit, resulting in the deletion of diagnosis codes and the return to Medicare of hundreds of millions of dollars related to those diagnoses.¹¹

We have specific concerns about inpatient RAPS data (see *Discussion of RAPS data* below for more detail). We analyzed RAPS data for 2015 and found:

- many more inpatient stays reported in RAPS data than in the encounter data or in the Medicare Provider Analysis and Review (MedPAR) data,
- a disproportionate share of RAPS inpatient stays with the same admission and discharge dates compared to encounter or MedPAR data, and
- 1.5 million RAPS inpatient stays that may have been outpatient or physician visits that were incorrectly recorded as inpatient stays in RAPS.

We conclude from our analysis that the provider type indicator in RAPS data does not accurately identify whether a diagnosis results from a hospital inpatient, hospital outpatient, or physician encounter. Therefore, we believe that the discrepancy in inpatient stays between RAPS and encounter data is largely caused by inaccuracy in the RAPS data. Not only does this analysis suggest that CMS should not pool inpatient RAPS data and encounter data, it adds to our concern about the accuracy of RAPS data overall.

Encounter data are more reliable than RAPS as a source of diagnostic data. The use of encounter data allows CMS to verify that risk adjustment criteria are met to a greater extent compared to the verification process for RAPS data. We believe that the front-end processing of encounter data before being accepted by CMS generates higher quality data relative to RAPS, which relies heavily on MA organizations' attestation that the data are complete and accurate. Although we have heard

¹⁰ Schulte, F. 2016. Medicare Advantage audits reveal pervasive overcharges. August 29.

<https://www.publicintegrity.org/2016/08/29/20148/medicare-advantage-audits-reveal-pervasive-overcharges>

¹¹ Department of Health and Human Services, Agency Financial Report, FY 2018. Department of Health and Human Services, Agency Financial Report, FY 2017. Department of Health and Human Services, Agency Financial Report, FY 2016. All available at: <https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html>

that many revisions to the encounter data submission process have caused some difficulty for plans, we interviewed several plans over the past year and most reported considerable investment in the infrastructure and processes to submit encounter data, and few identified ongoing issues with encounter data submission process. We believe the refinements CMS implemented have resulted in a more stable process for submissions.

Furthermore, encounter data offer value to many aspects of the Medicare program due to the many potential uses for encounter data in addition to risk adjustment. The administration of the Medicare program could be simplified by using encounter data where the program currently requires collection of similar data for bids, quality measurement, risk adjustment, calculation of disproportionate share hospital (DSH) and medical education payments to hospitals, and tracking limits on the Medicare benefit. The Commission believes that increasing the use of encounter data in risk adjustment and in other program operations, particularly for assessing quality in MA, would improve the completeness and accuracy of the data and would increase the reliability of the MA data used.

Finally, our analysis shows convergence in risk scores based on RAPS and encounter data: The share of MA enrollees with the same RAPS-based and encounter-based risk score increased from 91 percent in 2016 to 93 percent in 2017, and the overall difference between the two types of risk scores decreased by about one-half percent from 2016 to 2017 resulting in RAPS-based risk scores that were less than 2 percent larger than encounter-based risk scores in 2017. Several plans reported that they compare their RAPS and encounter data to ensure consistent risk scores. We believe the convergence in risk scores is due to a combination of increasing encounter data completeness, and plans returning payments that are based on unsupported RAPS diagnoses. Because the difference between RAPS-based and encounter-based risk scores is small and diminishing, CMS could fully switch from RAPS to encounter data for risk adjustment with minimal impact on plans.

Given our significant concerns about RAPS data and the greater reliability and potential value of encounter data, we urge CMS to continue to increase the use of encounter data and phase out the use of RAPS data for risk adjustment as expeditiously as possible. Specifically, CMS should use encounter data as the sole source of diagnoses for the PCC model in 2020 (with 50 percent weight) and in subsequent years as the PCC model is phased in, so that encounter data are the sole source of diagnoses for all 2022 payments to MA plans. CMS should no longer pool encounter data and inpatient RAPS data for any risk adjustment model. We believe this approach will improve the reliability of risk adjustment data and minimize complexities related to phasing in a new version of the CMS–HCC model (the PCC version of the model) and a new source of diagnostic data.

Discussion of RAPS data

We conducted the following analyses to evaluate CMS’s claim that inpatient encounter submissions are low relative to inpatient RAPS submissions, and whether pooling RAPS inpatient data with encounter data is appropriate. First, we compared inpatient stays reported in MedPAR data (which include “information-only” claims that hospitals submit to CMS for MA enrollees),

MA encounter data, and RAPS data for 2015 (the most recent year of encounter data available).¹² Table 1 shows the total number of inpatient stays and unique inpatient users in MA as reported in MedPAR data, encounter data, and RAPS data.

Table 1. Number of inpatient stays and unique users in MA, 2015

	MedPAR	Encounter	RAPS
Unique inpatient stays	3.8 M	4.1 M	6.4 M
Unique inpatient users	2.5 M	2.5 M	3.0 M

Note: MA (Medicare Advantage), MedPAR (Medicare Provider Analysis and Review), RAPS (Risk Adjustment Processing System). Unique inpatient stay defined as unique beneficiary ID, admission date, and discharge date combination. Unique inpatient user defined as unique beneficiary ID. Encounter and RAPS data include stays in short- and long-stay hospitals. Analysis excludes inpatient records for cost plans from all three data sources because inpatient stays for cost plan enrollees are processed and paid by fee-for-service Medicare, and therefore there are no MA encounter records for inpatient stays for cost plan enrollees.

Source: MedPAC analysis of 2015 MedPAR, encounter, and RAPS data.

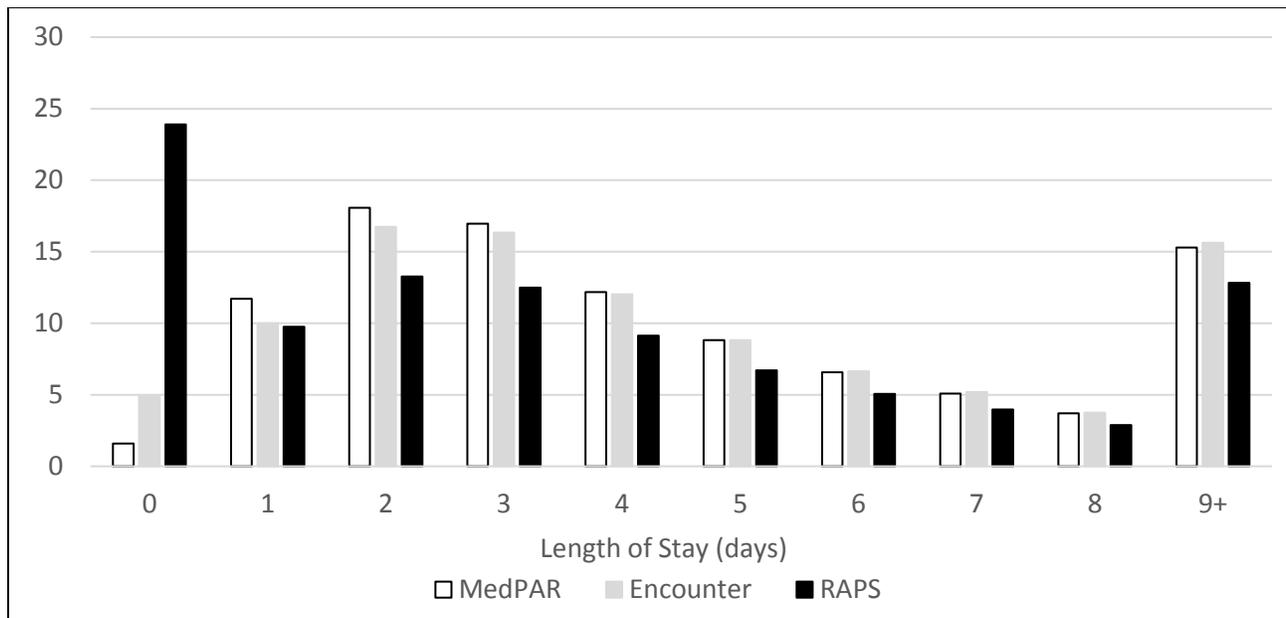
Table 1 supports CMS’s claim that there are more inpatient RAPS records than inpatient encounter records. However, we question whether the 6.4 million inpatient stays reported in RAPS data are accurate. One reason to question the accuracy of this estimate is that it would indicate that there were about 7 percent more inpatient stays per beneficiary in MA than in FFS Medicare.

To evaluate the RAPS data, we matched inpatient stays (based on combinations of beneficiary ID, admission date, and discharge date) with MedPAR and encounter data and found that 4.3 million inpatient stays in the RAPS data were also found in either MedPAR or encounter data. That leaves 2.1 million inpatient stays that were found only in RAPS data.

Next, we analyzed the length of stay for the inpatient stays reported only in RAPS data and found that 1.6 million stays had the same admission and discharge date. Figure 1 shows the proportion of inpatient stays by length of stay (where a length of stay of zero represents admission and discharge on the same day) for each of the three data sources. A disproportionate share of inpatient stays reported in RAPS indicate admission and discharge on the same day.

¹² Information about inpatient stays for MA enrollees is used to calculate Medicare’s disproportionate share hospital and indirect medical education payments to hospitals.

Figure 1. Percent of inpatient stays by length of stay, 2015



Note: MedPAR (Medicare Provider Analysis and Review), RAPS (Risk Adjustment Processing System). Length of stay of zero days indicates admission and discharge on the same day.

Source: MedPAC analysis of 2015 MedPAR, encounter, and RAPS data.

Given the disproportionate share of RAPS inpatient stays with admission and discharge on the same day, we considered whether outpatient or physician visits may have been incorrectly reported as inpatient stays in the RAPS data. To evaluate this possibility, we matched the 2.1 million inpatient stays reported only in RAPS with outpatient and physician encounter records (based on combinations of beneficiary ID, admission date, and discharge date) and found that 1.5 million matched a physician or outpatient encounter record. Although it may be possible to have a valid inpatient record with the same beneficiary ID, admission date, and discharge date as a valid outpatient or physician encounter record, we think this is rare and do not believe that it would account for the 1.5 million inpatient stays reported in RAPS matching a physician or outpatient encounter record.

Therefore, we conclude that the provider type indicator in RAPS data does not accurately identify inpatient stays, and a significant portion of the inpatient stays reported in RAPS are likely to be outpatient or physician visits. We believe the discrepancy in inpatient stays reported in RAPS versus encounter data that CMS observed is caused by inaccurate RAPS data rather than missing inpatient encounter records. The discrepancy in inpatient stays, and the assertion that the discrepancy was caused by missing encounter data, was the impetus for pooling inpatient RAPS and encounter data. Because we find the discrepancy is likely due to inaccurate RAPS data, we urge CMS not to pool inpatient RAPS data with encounter data as a source of diagnoses for risk adjustment.

Additional uses of encounter data

Potential changes to existing star rating and display measures

In addition to discussing the transition to the use of encounter data as the primary, and potentially exclusive, source of diagnostic data to be used in the risk adjustment system, the notice includes a discussion of additional uses of encounter data. Specifically, CMS evaluated the use of encounter data to establish the number of days an MA enrollee was an inpatient of a hospital or a skilled nursing facility (SNF) for the purpose of excluding those days from the Part D medication adherence star measures. Those days would be excluded from the proportion of days calculation (PDC) to determine the share of days “covered” by prescription claims for a given medication (which is the manner in which CMS judges adherence). For beneficiaries in stand-alone prescription drug plans (PDPs) who are in FFS Medicare, CMS uses hospital and SNF stay information from the Common Working File (CWF) to exclude inpatient days in the PDC. Both hospitals and SNFs submit informational claims that appear in the CWF data for MA inpatients in order to track a beneficiary’s utilization in relation to the day limits that apply to both FFS beneficiaries and MA enrollees (and beneficiaries in both MA and FFS during a benefit period). CMS evaluated the use of MA encounter data for this purpose and found that supplementing the CWF information with encounter data improved the ability to identify inpatient hospital and SNF stays.

CMS also proposed using encounter data to identify diagnosis codes for use in quality measurement. Some quality measures exclude certain groups of beneficiaries, defined on the basis of diagnosis codes, for whom it would be inappropriate to assess the measure. As noted earlier, CMS has collected diagnostic data for risk adjustment through RAPS data since 2004 and through the encounter data since 2012. CMS tested using encounter data—rather than RAPS data—to identify beneficiaries with an end-stage renal disease diagnosis for exclusion from the diabetes and hypertension medication adherence measures. CMS found that the encounter data yielded similar results to the RAPS results for MA prescription drug plans, and that “the impact of...removing RAPS [drug risk adjustment] data as a data source for PDPs was also negligible.”

CMS stated that the agency will continue to test using encounter data as the source of diagnoses for additional measures in Part D beyond the adherence measures.

Comment

The Commission supports CMS’s efforts to use encounter data as the source of information on diagnoses and utilization among MA enrollees for purposes beyond risk adjustment. Using encounter data for quality measurement can be particularly useful as a means of obtaining complete data for all enrollees reported in a uniform manner (as compared with using measures based on a sampling of medical records, for example). We encourage CMS to continue to take steps, as it is currently doing, to use encounter data more broadly and to ensure that encounter data reporting is both complete and accurate.

Medicare Advantage organizations crossing claims over to Medicaid agencies

In the notice, CMS has called attention to an issue affecting Medicare–Medicaid dually eligible beneficiaries in MA plans, and the need to develop an efficient means of informing state Medicaid programs when payment for Medicare cost sharing is required on behalf of these enrollees. For dually eligible beneficiaries in FFS Medicare, providers submit Medicare claims to the Medicare administrative contractors (MACs). If a claim is for a dually eligible beneficiary, the claim is automatically “crossed over” to the appropriate entity contracting with the state Medicaid agency for adjudication without the provider needing to file a separate claim with Medicaid. The claim will be processed by the Medicaid FFS contractor or a Medicaid managed care plan to determine any cost sharing that is payable to the provider. This crossover mechanism does not apply to enrollees of MA plans because providers do not submit claims to the MACs. For MA enrollees who are dually eligible, providers seeking payment of Medicare cost sharing must first identify, and then submit a claim to, the appropriate Medicaid entity—either the Medicaid FFS claims processor if the beneficiary is in FFS Medicaid, or the appropriate Medicaid managed care plan.

CMS is asking commenters to identify ways of implementing a crossover process for cost-sharing claims for dually eligible individuals in MA plans, and “ways to promote MA plans automatically crossing over cost-sharing claims to state Medicaid agencies and Medicaid managed care plans for dually eligible individuals.”

Comment

One method of establishing an automatic transfer for determining Medicaid cost sharing payments is to use MA encounter data as the source of data that can be forwarded to Medicaid claims processing entities. MA plans already have a process for adjudicating claims from providers and submitting data to the CMS encounter data contractor in a standard claim format. Claims for dually eligible MA plan enrollees could in turn be processed by the crossover claims contractor for forwarding on to the appropriate Medicaid entity. Because plans submit data in a standard format to the CMS encounter data contractor, we do not think there would be issues with data format differences. The process of identifying Medicaid enrollment status and the appropriate Medicaid entity for crossover could be the same as for dually eligible beneficiaries in FFS Medicare.

The overall process would be similar to the process in FFS Medicare with one exception. Knowing the specific amount that the MA plan paid to the provider is necessary for determining the appropriate Medicaid cost sharing liability, if any. Some MA plans have capitated payment arrangements with some providers, and therefore some services do not have a specific payment amount. (In the encounter data, a specific payment amount is not required for encounters provided under a capitated arrangement.) This issue is independent of using encounter data for the crossover claims process as capitated providers currently face this issue when trying to collect cost sharing from Medicaid entities. Depending on how this issue is currently addressed by providers under capitated payment arrangements, a similar process would need to be applied when establishing the automatic crossover of data to Medicaid payment entities.

Dual-eligible special needs plan (D–SNP) “look-alikes”

D–SNPs are specialized MA plans that serve individuals who qualify for both Medicare and Medicaid. These plans must meet a number of additional requirements that do not apply to regular MA plans. For example, all D–SNPs must have Medicaid contracts that meet certain standards and follow an evidence-based model of care that has been approved by the National Committee for Quality Assurance.

In recent years, some plan sponsors have begun offering regular MA plans that are targeted at dual eligibles (beneficiaries eligible for both Medicare and Medicaid). These plans are often referred to as “look-alike” plans because they resemble D–SNPs in some ways. For example, look-alike plans tend to have more generous coverage of dental, hearing, and vision benefits that Medicare does not cover. However, since look-alike plans operate as regular MA plans, they are not subject to the extra requirements for D–SNPs, like the Medicaid contracting requirement. The growth in look-alike plans has been particularly noticeable in California, where plan sponsors have used look-alikes to circumvent restrictions on D–SNPs that are part of the state’s financial alignment demonstration. We discussed this issue in greater detail in our June 2018 report to the Congress.

Comment

In the draft Call Letter, CMS requested comments on the impact of look-alike plans. Based on the experience in California, the Commission is concerned that look-alike plans may undermine federal and state efforts to integrate Medicare and Medicaid for dual eligibles through products such as highly integrated D–SNPs or Medicare–Medicaid Plans. At its November 2018 meeting, the Commission noted that policymakers may want to consider restricting the use of look-alike plans by (1) giving CMS the authority to reject applications to offer regular MA plans that appear to be targeted at dual eligibles and (2) requiring look-alike plans that are already on the market to meet the added requirements for D–SNPs, such as having a Medicaid contract.

Conclusion

The Commission values the ongoing cooperation and collaboration between CMS and our staff on technical policy issues. We look forward to continuing this productive relationship. If you have any questions, or require clarification of our comments, please feel free to contact James E. Mathews, the Commission’s Executive Director, at 202-220-3700.

Sincerely,



Francis J. Crosson, M.D.
Chairman