MEDPAC Medicare Payment Advisory Commission

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February 23, 2018

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) 2019 for Medicare Advantage (MA) CMS–HCC Risk Adjustment Model, Capitation Rates, Part C and Part D Payment Policies and 2019 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 27, 2017 "Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for the Medicare Advantage (MA) CMS–HCC Risk Adjustment Model" and the February 1, 2018 "Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 Draft Call Letter" (collectively, the Advance Notice). We appreciate your staff's work on the notice, particularly considering the statutory requirements for changes to the risk adjustment model.

Our comments focus on the following issues:

- Proposals to implement Part C risk adjustment model changes required by the 21st Century Cures Act: using at least two years of diagnostic data, evaluation of chronic kidney disease, three-year phase-in of risk adjustment model changes, and encounter data as a source of diagnoses for 2019
- Contract consolidations and the quality bonus program
- Calculation of fee-for-service cost
- MA employer group waiver plans
- MA coding pattern adjustment

Risk adjustment model changes: Using at least two years of diagnostic data

The 21st Century Cures Act states that "the Secretary may use at least two years of diagnosis data" in refining the risk adjustment model used for Medicare Advantage.

Part 1 of the Advance Notice, addressing 21st Century Cures Act mandates, does not discuss this provision. On page 23, CMS states that the agency believes that the statutory language requiring the phase-in of Cures Act provisions over three years between 2019 and 2022 (i.e., a four year time period) allows flexibility for CMS to address the mandates starting in either 2019 or 2020. Implicitly, then, we would expect that CMS would have to address the use of two years of diagnostic data no later than in next year's Advance Notice for 2020.

Comment

In our 2016 report to the Congress, the Commission recommended that CMS use two years of fee-for-service (FFS) Medicare diagnostic data to calibrate the risk adjustment model and two years of MA diagnostic data to determine MA risk scores. Using two years of data improves the accuracy of the diagnostic information used in risk adjustment, reducing the year-to-year variation in documenting chronic conditions. Because it improves FFS diagnostic coding data, using two years of diagnostic data has the additional effect of reducing diagnostic coding differences between FFS Medicare and MA, and reduces the need for the Secretary to apply an adjustment.

While the 21st Century Cures Act gives the Secretary discretion to use at least two years of diagnostic data, we believe that the Secretary should indeed do so. We understand that the transition from ICD–9 to ICD–10 diagnoses on October 1, 2015, may lead CMS to wait until 2020 to calibrate a model that uses two consecutive years of data. A model calibrated using 2015 and 2016 diagnoses to predict 2017 costs would use ICD–10 diagnoses for the majority of the diagnostic data collection period, and all the data necessary to perform a calibration on these years of data would be available in advance of the 2020 payment year announcement. CMS should propose a method using two years of diagnostic data starting in 2020.

Evaluation of chronic kidney disease

The 21st Century Cures Act required the Secretary to evaluate the impact of including the severity of chronic kidney disease (CKD) in the model. The Advance Notice recognizes the clinical classification of CKD into 5 stages based on the ability of the kidneys to remove waste from a person's blood. Stage 1 has the lowest severity, and stage 5, also called end-stage renal disease, represents kidney failure and requires dialysis treatment or kidney transplantation for most patients. CMS evaluates the severity of CKD as codified in hierarchical condition categories (HCCs) for inclusion in the risk adjustment model. Stages 4 and 5 CKD each have an independent HCC and are currently included in the risk adjustment model.

CMS is proposing to add an HCC for stage 3 CKD, but notes that stage 3 includes a wide range of kidney function and variation in the severity of CKD. CMS recognizes that stage 3 is divided by severity into stage 3a (mild to moderate severity) and 3b (moderate to high severity) based on the waste filtration rates of blood and is further sub-divided based on the presence of albumin protein in urine, a condition called albuminuria. Due to a lack of clinical meaningfulness, CMS is not proposing to add an HCC for beneficiaries with stages 1 or 2 CKD, or unspecified stage CKD.

Comment

The Commission is concerned about the inclusion of stage 3 CKD as an individual HCC. In the 2014 Advance Notice, CMS reported that it had removed stage 3 CKD from the risk adjustment model due to concerns about the high rate of coding by MA organizations relative to FFS providers. We share CMS's concern about MA coding of an HCC for stage 3 CKD, and the potential to increase overpayments due to coding differences.

Furthermore, we are concerned that patients with stage 3 CKD are not a clinically homogenous group. Patients with stage 3 CKD can have a wide range of kidney function, from mildly to severely decreased function, whereas kidney function for patients with CKD stage 4 (severely decreased function) or stage 5 (kidney failure) is more uniform. Similarly, there is significant variation in the prognosis for patients with stage 3 CKD. Taking into account the albuminuria level, stage 3 CKD includes moderate, high, and very high risk categories.[1] We also note that CMS finds little statistical benefit to including a stage 3 CKD HCC in the model. Stage 3 CKD coefficients are very small in the "payment condition count" model, and are constrained to zero (due to being negative) in the "all condition count" model. Such coefficients are consistent with the wide range of severity and risk that stage 3 CKD encompasses.

Given the potential for overpayment, the lack of clinical homogeneity in the stage 3 CKD population, and the low statistical performance, we believe that CMS should not include a stage 3 CKD HCC in the model. If CMS were able to incorporate clinical data, such as waste filtration rate and albuminuria level, a more clinically meaningful sub-population of stage 3 CKD patients with high risk factors could be identified.[1] The incorporation of clinical data would reduce concerns about coding, and CMS could evaluate an HCC for high-risk stage 3 CKD for inclusion in the risk adjustment model.

Three-year phase-in of risk adjustment model changes and encounter data as a source of diagnoses for 2019

CMS notes that the risk adjustment changes in the 21st Century Cures Act must be phased in over a three-year period, beginning in 2019, with such changes being fully implemented for 2022 and subsequent years. Thus, CMS asserts that the Act requires a three-year phase-in over four years, allowing flexibility to either begin implementing risk adjustment changes in 2019 and phase them in through 2021, or use 2019 to gather comments and reconsider options to propose for 2020, with a phase-in through 2022. CMS requests comment on these options.

CMS proposes to phase in risk scores based on the "payment condition count" model by weighting 25 percent of 2019 payment on these risk scores. CMS also proposes using encounter data as the data source for these risk scores, with the addition of diagnoses from inpatient risk adjustment

[1] KDIGO 2012 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. *Official Journal of the International Society of Nephrology*. 3(1): 2013. See page *x*: http://www.kdigo.org/clinical_practice_guidelines/pdf/CKD/KDIGO_2012_CKD_GL.pdf.

processing system (RAPS) data. The remaining 75 percent of 2019 payment would be based on the risk adjustment model used in 2017, with RAPS data used as the data source. CMS also laid out a phase-in schedule that increases the proportion of payment based on the "payment condition count" model risk scores by 25 percentage points each year until the new model is fully phased in for 2022 payment.

CMS observes that encounter data inpatient submissions were low relative to RAPS inpatient submissions and states that supplementing encounter data with diagnoses from inpatient RAPS data would improve completeness. CMS has already extended encounter data submission deadlines for years that rely on encounter data (2016 and 2017) as a strategy to improve plan's submission of encounter data and ensure that payments are accurate.[2]

Prior to using encounter data in risk adjustment, CMS filtered all physician data using the physician specialty code to ensure risk adjustment eligibility. This filtering method was applied to FFS data used to calibrate the risk adjustment model and to the RAPS data used to calculate MA risk scores. For encounter data, however, CMS began applying a filter using CPT/HCPCS codes, providing transparency in the method to plans (the database used to identify physician specialty is not public). Filtering FFS data by physician specialty and MA encounter data by CPT/HCPCS code creates a misalignment in the filtering method that can diminish the accuracy of the model. The Advance Notice proposes to align the filtering methods by applying the same filter (CPT/HCPCS code) to the FFS data used to calibrate the "payment condition count" and the encounter data used to calculate risk scores for that model. Similarly, CMS will apply the same filter (physician specialty code) to the FFS data used to calibrate the 2017 risk adjustment model and the RAPS data used to calculate risk scores for that model.

Comment

We believe that CMS should proceed with the planned proposals for 2019 and continue the scheduled phase-in. We also support the increase in use of encounter data for payment, from 15 percent in 2018 to 25 percent in 2019. As we have stated in recent reports to the Congress and comment letters to the Secretary, we fully support CMS's efforts to collect encounter data and increase the proportion of MA payment based on encounter data.

Inpatient RAPS diagnoses should not be added to the encounter data as a source of diagnoses for the "payment condition count" model. We strongly disagree with CMS's inference that RAPS data is the standard by which encounter data submissions should be measured. The validity of encounter data is maintained through CMS's front-end system of checks, and CMS ensures that diagnoses from encounter data meet the criteria for risk adjustment. These aspects are attested to for RAPS data, but no external validation takes place before payments are sent to plans. For these reasons, we believe encounter data should be the basis for MA payment. Given that CMS has found a difference in RAPS and inpatient encounter submissions in the past, we support CMS's decision to extend the submission deadlines, providing MA organizations time to ensure that their

[2] HPMS memo, February 20, 2018, "CORRECTION – Updated Announcement Regarding Encounter Data Deadlines for Payment Years 2016 and 2017 Final Reconciliation," CMS Medicare Plan Payment Group.

submission of inpatient encounters is complete and accurate. We believe that MA plans will have had ample opportunity to address the source of any differences in their inpatient encounter submissions for 2018 dates of service, the year of diagnostic data used to determine 2019 payments.

We support the use of encounter data as the data source for the proposed "payment condition count" model and the alignment of filtering method applied to both the encounter data and the FFS physician data used to calibrate the model. CMS should continue to use encounter data as the source for risk scores from the "payment condition count" model in future years in order to maintain the alignment of the filtering methods.

Contract consolidations and the quality bonus program

The portion of the Advance Notice dealing with contract consolidations and their effect on star ratings refers to the recently released notice of proposed rulemaking (NPRM, CMS–4182–P, published November 28, 2017) in which CMS proposed to formalize the procedures for determining star ratings in the MA quality bonus program. The final rule will state CMS's policy on star ratings. The NPRM addresses an issue that has been of concern to the Commission, which is the use of contract consolidations to boost the star ratings of lower-performing MA contracts not eligible for bonus payments. By consolidating contracts, a company can have the bonus-level star rating of one contract applied to a contract or contracts that are being absorbed by (consolidated with) the bonus-level contract. This results in unwarranted bonus payments for what would otherwise be non-bonus-eligible contracts.

The approach proposed in the NPRM to address the concern with the consolidation strategy was to use an averaging method for the initial year of consolidation, which is the approach enacted in the Bipartisan Budget Act of 2018. Under the averaging method, in the first year of the consolidation CMS would take the enrollment-weighted average result for each measure in the star ratings to determine a new star rating for the combined contract. After the first year, the consolidated contract would receive a star rating based on its reporting of quality measures for the combined enrollment.

Comment

We share CMS's concern with the consolidation strategy and the desire to limit the degree to which companies can inflate star ratings and receive unwarranted bonuses through this strategy. We commend CMS for proposing a method of addressing the issue. The policy that CMS proposed, and which is now in the statute, dampens the incentive to use the consolidation strategy as a means of obtaining unwarranted bonus payments.

The Commission has been calling attention to the consolidation issue over the past several years (see, for example, the March 2017 report to the Congress). At the January 2018 public meeting, the Commission made two recommendations to address the issue. The first recommendation differs from the averaging method proposed by CMS in that it calls for CMS to retain the reporting units

in place prior to consolidation as the units for determining star ratings. The Commission discussed the averaging method and commented on the approach in our January 3, 2018, comment letter on the recently released NPRM. The averaging method does foreclose certain types of combinations that have occurred in the past, but would continue to provide an incentive for organizations to consolidate contracts and thus obtain unwarranted bonus payments. For example, two contracts with equal enrollment, one with a 4.5-star rating and one with a 3.5-star rating, could be combined to result in what would likely be a 4-star consolidated contract. Moreover, the averaging method does not give an accurate representation of quality in a given geographic area when multiple geographic areas are combined under a single contract.

The Commission's second recommendation from the January 2018 meeting is a way of addressing concerns over the effect of consolidations on star ratings as well as addressing the long-standing concern that the Commission has had with the manner in which MA quality is reported for bonus purposes and for public reporting. Consistent with its past recommendations on the reporting unit for MA quality, the Commission's second recommendation calls for quality to be reported at the level of the local health care market area designated by the Secretary. For example, if each metropolitan statistical area (MSA) was considered to be a market area, every MA contract would report separate quality results for each MSA it served. These local-level results would be used to compare the performance of one MA plan with that of others in the same market area, and the information would be used in a comparison with quality results for FFS, which would also be reported at the MSA level.

The local-level reporting has long been the Commission's preferred approach to MA quality reporting (see the summary discussion in the Commission's March 2010 report on how quality should be measured in MA and how it could be compared to quality in FFS). Local-level reporting is far preferable to the current situation of contract-level reporting. In part because of the trend of contract consolidations, many MA contracts cover wide multi-state geographic areas. Currently, about one-third of HMO enrollees in MA are in a contract that covers two or more states, and nearly 20 percent are in contracts covering four or more states. Contracts include state combinations such as Hawaii and Iowa, Oregon and Delaware, or Texas and Maryland. Contract-level reporting of quality (as reflected in the current CMS policy) often misrepresents the quality of care in a specific geographic area—either overstating or understanding the quality of a local plan. Consistent with our comments on the recent NPRM, and consistent with our recent and past recommendations, we urge CMS to begin the process of reporting quality at the local level as soon as possible.

Calculation of fee-for-service cost

To set MA county benchmarks, CMS must calculate the average per capita FFS spending in each county. CMS measures average FFS spending for all FFS beneficiaries in a county who have either Part A or Part B of Medicare, or both. Average Part A spending is calculated using all beneficiaries enrolled in Part A, including beneficiaries enrolled in both Part A and Part B, as well as those with only Part A and not Part B (Part A-only). Similarly, average Part B spending is calculated for all beneficiaries enrolled in Part B, regardless of whether the beneficiaries are also

enrolled in Part A. Those two averages are added to get the relevant FFS total. However, to be eligible to join an MA plan, a beneficiary must be enrolled in both Part A and Part B. Medicare FFS spending is higher for beneficiaries in both Parts A and Part B than those who are in Part A-only. Thus the benchmarks resulting from the current calculation method could result in systematically under-estimated benchmarks in counties with relatively low Part B enrollment.

For the past several years CMS has been calculating FFS spending using fee-for-service spending data only for beneficiaries enrolled in both Part A and Part B for Puerto Rico, and otherwise uses the method described above. CMS argues that Puerto Rico is different because Puerto Rican residents have to actively choose to join Part B when they are eligible (opt-in), while residents of the 50 states and the District of Columbia must actively choose *not* to join Part B when eligible (opt-out). More than half of beneficiaries in Puerto Rico have Part A, but not Part B, compared with about 9 percent of all beneficiaries. In this Advanced Notice, CMS discusses the situation in Puerto Rico, but does not discuss expanding the method to the rest of the country, as it has discussed in the past.

Comment

In the Commission's March 2017 Report to the Congress, we recommended that "The Secretary should calculate Medicare Advantage benchmarks using fee-for-service spending data only for beneficiaries enrolled in both Part A and Part B."

In our analysis, we found that the average risk-adjusted per beneficiary spending is higher for beneficiaries enrolled in Part A and Part B than the sum of the spending for all beneficiaries enrolled in Part A and all beneficiaries enrolled in Part B. We also found that over time, a higher percentage of Medicare beneficiaries are joining MA plans, and a higher percentage of those remaining in FFS Medicare do not enroll in Part B. That is, high MA penetration leaves fewer, and a less representative population of, beneficiaries on which to calculate FFS spending. As MA penetration continues to grow, we expect these calculation problems to grow. Currently, we do not have evidence that CMS's calculation method has caused harm, in terms of plan access or quality, to the MA program in the affected counties, but for the sake of accuracy and avoiding future problems, the FFS calculation should be corrected to ensure that the population used to calculate FFS spending is representative of the expected spending for MA beneficiaries. We understand that by itself our recommendation would result in an increase in payments to MA plans. However, the Commission has made other recommendations (e.g., increasing the coding intensity adjustment to more accurately compensate for plan coding practices) for improving the accuracy of payments to MA plans that would reduce such payments. Taken together, our recommendations could result in fairer, more accurate payments to plans (without increasing program spending).

MA employer group waiver plans

In the Final Notice for 2017, CMS announced that it would waive bid submission of employer group waiver plans (EGWPs) and would instead pay them based on the bids of the non-employer plans (as it does in Part D). This change was done because EGWPs did not have the same

incentives as the non-EGWPs to bid low to attract enrollment, and would have the effect of lowering Medicare payments to EGWPs by 3.6 percent. In calculating payments, CMS assumed each EGWP would bid the same percentage of its benchmark as the average percentage reflected in the bids of the non-employer plans. The new payments were to be phased in over two years beginning in 2017.

For 2017 the bid-to-benchmark percentages were blended to be 50 percent of the average EGWP percentages for each of the Patient Protection and Affordable Care Act MA payment quartiles and 50 percent of the non-employer percentage for each quartile. With the two-year transition, the average payment change in 2017 reflected only half of the CMS-estimated 3.6 percent full reduction. The reduction would vary by plan. The payment change would have minimal effects on those EGWPs that submitted bids that were similar to non-employer bids (in fact, some EGWPs would see an increase in payments). However, many EGWPs simply bid at the benchmark, which maximizes their Medicare program payments. Those EGWPs would see a reduction in their Medicare payments, as intended by the policy.

In the 2018 Advance Notice, CMS raised the possibility of not doing the second year of the transition in 2018, and it announced in the Final Notice for 2018 that it would use the same 50/50 blend of the 2016 EGWP bid-to-benchmark percentages and current non-EGWP percentages that were used to determine 2017 EGWP payments to also determine the 2018 EGWP payments, again limiting the impact of the policy change.

For 2019, CMS is proposing to complete the transition and use only the non-EGWP percentages to calculate the "bids" from which payments for each EGWP would be determined. The risk scores and counties of residence of plan enrollees, as well as the plans' quality scores would also factor into the final payment calculations for each plan. However, CMS notes it is still considering another year of the 50/50 blend. It is also considering adjusting the bid-to-benchmark percentages to reflect the facts that PPOs tend to bid higher relative to the benchmarks than HMOs, and that EGWPs are more likely to be PPOs than non-EGWPs. Any of these alternatives is likely to raise the payments to the EGWPs relative to the proposed completion of the transition.

Comment

The Commission recommended, in its March 2014 Report to the Congress, that the Secretary "…determine payments for employer group Medicare Advantage plans in a manner more consistent with the determination of payments for comparable non-employer plans." The Commission made this recommendation because the bids from the EGWPs were consistently higher than the bids from comparable non-employer plans. The non-employer plans are under pressure to submit bids low enough to attract enrollment. In contrast, EGWP bids are not submitted to attract enrollment. EGWP enrollment is negotiated with employers, and the benefit packages and premiums that the plans offer to the employers are not necessarily reflected in the bids.

Lower Medicare payments do not seem to have harmed EGWPs' ability to attract enrollment. From December 2016, the last month that payments were based on each EGWP's bid, to February

2018, enrollment in EGWPs grew by 28 percent while non-EGWP enrollment grew by 10 percent. Further, enrollment in EGWP PPOs was certainly not discouraged, as it grew by 44 percent, or 900,000 enrollees. In addition, plans may find that the payment reduction is worth the savings in time and cost that come with the elimination of bid preparation. We urge that CMS complete the transition in 2019 as originally described in its 2017 Final Notice.

MA coding pattern adjustment

CMS makes an adjustment to MA risk scores to account for differences in MA and FFS diagnostic coding that can result in overpayments to MA plans. For 2019, CMS proposes to apply the statutory minimum coding pattern adjustment of 5.9 percent. CMS is also considering an alternative adjustment for 2019 based on one of three methodologies: CMS's original method for determining the impact of coding differences (from the 2010 Advance Notice); a method that uses the average adjusted average per capita cost (AAPCC) as an upper bound for risk score increases (from the 2016 Advance Notice); and the method recommended by the Commission in 2016 and elaborated on in MedPAC's March 2017 report to the Congress.

Comment

In developing a method of adjusting for coding differences, the Commission focused on two key aspects: adjusting for the full impact of coding differences, and applying the adjustment in a way that is equitable across MA contracts. We consistently have found that (1) the impact of coding differences is larger than the statutory minimum adjustment, so that the MA program paid plans 2 to 3 percent more than intended by the payment policy in 2016, and (2) coding intensity varies significantly across MA contracts, so that some contracts are unduly penalized by the statutory across-the-board adjustment, while others retain a significant amount of coding-related payment even after the adjustment.

The method recommended by the Commission has 3 parts.

- First, remove diagnoses from health risk assessments (HRAs). HRAs are a beneficial tool in developing a care plan for a beneficiary; however, they are not a good indicator of the resource use for risk adjustment. HRAs often rely on patients to confirm a health condition, and if assessments lead to appropriate follow-up care, the risk adjustment system will collect the diagnostic information during the actual treatment for the condition.
- Second, use two years of diagnostic data for risk adjustment. Using two years of data improves the accuracy of both the FFS data used to calibrate the model and the MA data used to calculate risk scores. We believe the intent of the 21st Century Cures Act is for the Secretary to use two years of diagnostic data for risk adjustment, and, as we state above, we believe that the Secretary should do so.
- Third, CMS should calculate the remaining impact of coding differences after implementing the first two parts of the method, and then adjust risk scores by that amount. In our 2017 report to the Congress, we explained that this adjustment could be implemented by ranking MA contracts by coding intensity and then applying an adjustment

for low, medium, and high coding-intensity contracts that is proportional to the difference in coding intensity between the groups. Such a tiered adjustment would improve the equity of the adjustment relative to the actual impact of coding intensity on payments to a contract.

We believe that the MedPAC method appropriately adjusts for the full impact of coding intensity and provides an equitable adjustment that reduces the incentive for MA plans to code diagnoses more intensively.

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