MEDPAC Medicare Payment Advisory Commission

425 I Street, NW • Suite 701
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Francis J. Crosson, M.D., Chairman
Jon B. Christianson, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

February 24, 2017

Patrick Conway, MD, MSc
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 310G.05, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Dr. Conway:

The Medicare Payment Advisory Commission (MedPAC) is pleased to provide comments on the Centers for Medicare & Medicaid Services' (CMS's) February 1, 2017, Advance Notice of Methodological Changes for Calendar Year (CY) 2018 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2018 Call Letter (the Advance Notice). We appreciate your staff's work on the notice, particularly given the competing demands on the agency.

Our comments deal with several issues: payments to MA employer group waiver plans (EGWPs), use of encounter data for risk adjustment, and issues related to the quality bonus program and the determination of star ratings.

Payments to employer group waiver plans

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.

In the Final Notice for 2017, CMS announced that it would waive bid submission of EGWPs and would instead pay them based on the bids of the non-employer plans (as it does in Part D). The new payments were to be phased in over two years beginning in 2017. 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. For 2017 the bid-to-benchmark percentages were blended to be 50 percent of the average EGWP percentages for each quartile, 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 (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.

Comment

In the 2018 Advance Notice, CMS raises the possibility of not doing the second year of the transition in 2018. CMS did not indicate why it questions the completion of the transition, but the just-released enrollment figures suggest that the EGWPs are still thriving under the new payment formula as enrollment in February 2017 (under the new system) grew 14 percent from December 2016 (under the old system). Further, MedPAC staff were told by some plans that the payment reduction was worth the saving in time and cost that came with the elimination of bid preparation. We believe that CMS should complete the transition in 2018 as originally described in its 2017 Final Notice.

Use of encounter data for 2018 payment

Medicare pays MA plans a risk-adjusted rate that is higher for beneficiaries with more health conditions, or hierarchical condition categories (HCCs), and lower for beneficiaries with fewer conditions. The mechanism that increases or decreases the payment rate is called a risk score and is made up of demographic information and HCCs. HCCs are identified by diagnostic data that plans submit to CMS, currently through two pathways. Since 2004, CMS has based payment on Risk Adjustment Processing System (RAPS) data, which is a limited set of data that contains only the information needed to identify an HCC for a beneficiary. In 2012, CMS began collecting a broader set of data through the Encounter Data System (EDS), which captures detailed information about each encounter that a beneficiary has with a provider, and which also includes the information necessary to identify HCCs for each beneficiary.

Only diagnoses resulting from a hospital inpatient stay, hospital outpatient visit, or a face-to-face visit with a physician or qualified health professional (hereafter referred to as clinicians) are used to identify HCCs. For RAPS data, plans are required to ensure that all diagnoses submitted are eligible for risk adjustment by ensuring that they meet certain criteria. For EDS data, plans submit full encounter records and CMS applies filters to ensure that diagnoses meet the criteria. However, the criteria used to filter clinician data are different for RAPS and EDS:

- In RAPS, risk adjustment eligibility is based on clinician specialty. Diagnoses are eligible for risk adjustment if they result from a visit with a clinician whose specialty is designated on a list of 73 acceptable specialties (including "unknown" specialty) maintained by CMS.
- For EDS, risk adjustment eligibility is based on the procedure (CPT/HCPCS) code used to identify the clinician service provided during the visit (e.g., evaluation and management services). Diagnoses are eligible for risk adjustment if they result from a clinician visit with a procedure code from the CMS-maintained list of more than 6,400 codes.

Encounter data were first used for payment in 2015 by adding all diagnoses from the two data sources together to generate a single risk score, meaning HCCs were identified by either RAPS or EDS data. For 2016 payment, CMS generated two risk scores, one based on RAPS data and one based on EDS data, and then combined the risk scores using a 10 percent EDS / 90 percent RAPS blend. Last year, CMS laid out plans to slowly increase the EDS portion of the blend to 25 percent in 2017, 50 percent in 2018, 75 percent in 2019, and finally 100 percent in 2020.

However, for 2018 payment CMS has now proposed (a) to keep the risk score blend the same as 2017 at 25 percent EDS / 75 percent RAPS risk scores, and (b) to adjust the EDS portion of the risk score to address differences from RAPS risk scores (e.g., an adjustment could increase the average EDS risk score to be equal to the average RAPS risk score).

Impact of using EDS data for plan payment. There are two reasons that using EDS data to identify HCCs could affect payment to plans relative to RAPS data. First, if plans do not submit encounters to support each HCC that is submitted through RAPS, EDS risk scores and the RAPS/EDS blended payment rate would be lower. Plans have used clinician and hospital encounter information to generate RAPS data since 2004, and have been submitting encounter information through EDS since 2012.

Second, the different methods of filtering clinician data in RAPS and EDS could affect which clinician visits are determined to be eligible for risk adjustment, and therefore identify different HCCs. Because the database used in RAPS filtering where clinician specialty information is stored is not publicly available, CMS decided to use procedure codes to filter EDS clinician data. CMS published the list of eligible procedure codes and the logic used to determine which codes would be included. Generally, procedure codes that identify face-to-face procedures or services during which a clinician is able make a diagnosis are included.[a]

Comment

MedPAC commends CMS on its efforts to collect encounter data from MA plans. The data are invaluable for assessing MA innovations in resource use, determining plan quality, calculating disproportionate share payments, tracking lifetime limits on Medicare benefits, and improving MA payment accuracy.

[a] We believe that the procedure code-based criterion is a more accurate way of identifying eligible clinician encounters for risk adjustment, compared to a clinician specialty-based criterion, and CMS should continue to use this filtering method for clinician encounters.

In response to the request for comment on (a) keeping the risk score blend the same as 2017 at 25 percent EDS / 75 percent RAPS risk scores, and (b) adjusting the EDS portion of the risk score to address differences from RAPS risk scores, we considered the two reasons using EDS data could affect risk scores and payments to plans.

Due to concern about some plans having difficulty submitting sufficient EDS data to CMS, we believe it is acceptable to use the 2017 risk score blend (25 percent EDS / 75 percent RAPS) so that those plans have additional time to refine EDS data submission processes. However, we do not support an adjustment to the EDS portion of the risk scores to address this issue. Using EDS data for plan payments is currently the only tool CMS has to encourage complete submission of encounter data, and we believe it is crucial for CMS both to exert financial pressure on plans to submit encounter data, and also facilitate plans' ability to appropriately structure the data for processing through the encounter data system in order to ensure that final encounter data are complete and accurate. The proposed adjustment would reduce the incentive to submit complete encounter data, preserve the notion of RAPS as the basis for payment, and hinder the transition to EDS-based payment.

To address any differences in EDS and RAPS risk scores that result from the differing clinician encounter filtering methods, we believe that the two filtering methods should be applied to FFS data in proportion to the payment blend during the calibration of the risk adjustment model. Risk score differences resulting from the two filtering methods will not diminish over time, and once plan payment is based entirely on EDS data, the FFS-calibrated coefficients should use the same procedure code-based clinician encounter filter as the EDS data used to pay plans.

As we have stated before, the Commission strongly supports the principle that Medicare payment policy should not favor Medicare Advantage or FFS Medicare. When it comes to data filtering for MA risk adjustment, the principle implies that the FFS data used for model calibration are treated the same way as the MA data used to calculate risk scores.

Issues in the star rating system

Duration of bonus status for low-enrollment contracts—The Commission believes that CMS should consider a change to the treatment of low-enrollment contracts with regard to their eligibility for bonuses under the quality bonus program (QBP). The statute provides that low-enrollment contracts would be QBP-"qualifying" contracts in 2012, but that in 2013 and thereafter "the Secretary shall establish a method to apply to MA plans with low enrollment…the computation of quality rating and the rating system under…[the star system]" (section 1853(o)(3)(A)(ii) of the Social Security Act).

The statute did not specify the bonus level for low-enrollment plans, but CMS has relied on the provisions dealing with new plans to give low-enrollment plans a 3.5 percent bonus (p. 13 of the Advance Notice). The statute provides that new contracts will be "qualifying" contracts for bonus

purposes and will receive a 3.5 percent QBP bonus for a three-year period, rather than the 5 percent bonus for contracts with a rating at or above 4 stars.

CMS has a policy of terminating low-enrollment plans (p. 113 of the Advance Notice). Plans with fewer than 500 enrollees, or special needs plans with fewer than 100 enrollees, are terminated after three years unless the plan can be subsumed under another contract, is operating in an area with few MA options, or can provide a justification for continuing as a plan.

Comment

We are unsure whether it is consistent with the statute, and with other CMS policies, to continue to provide bonuses to low-enrollment contracts beyond a certain period of time. The wording of the statute contemplates a temporary granting of bonus status to low-enrollment contracts—only for 2012—with the expectation that after 2012 there would be a means of giving a low-enrollment contract a quality rating. As of 2016, CMS has been computing star ratings with contract enrollment of between 500 and 1000 enrollees, but not for contracts with fewer than 500 enrollees.

Consistent with the policy of terminating low-enrollment plans or encouraging consolidation of such plans, and consistent with the statutory three-year duration of the deemed QBP-qualifying status of new contracts, the Commission believes that CMS should either (a) propose a method of evaluating the quality of low-enrollment plans for QBP purposes; or, if (b) there is a justification for continuing a low-enrollment contract, limit its deemed QBP-qualifying status to three years.

Using the Beneficiary Access and Performance Problems measure as the means of addressing how a sanctioned plan will have its star rating affected—The Advance Notice proposes to replace the current (but suspended) policy of reducing a contract's QBP star rating to 2.5 stars if a contract is under sanctions. Instead, the sanction status of a contract will affect only one measure in the star rating system—the Beneficiary Access and Performance Problems (BAPP) measure. That measure is currently weighted at 1.5 out of a total of 78.5 possible points.

The change would be a major reduction in the financial impact a company would face when under sanction. A contract that would otherwise be eligible for bonus payments because of a rating of four stars or higher, would lose revenue in the range of $40 per-member-per-month under the prior policy. That loss of revenue would be in addition to any civil money penalties (CMPs) imposed, and any suspension of enrollment that would also result in lost revenue for a company.

Comment

In weighing whether this major change is appropriate, CMS should consider whether there is a sufficient deterrent effect in the remaining financial impact (of a CMP and/or suspension of enrollment) if bonus payments are unaffected, and whether the remaining financial penalty is commensurate with the infractions or violations giving rise to the sanctions. CMS may wish to consider having the option of reducing bonus payments (for example, to the 3.5 percent level, if not completely) in particularly egregious cases.

Reducing a contract's star rating to 2.5 stars enables beneficiaries to become aware of contract performance issues. If CMS proceeds with replacing the prior policy with a reduction applied solely to the BAPP measure, beneficiaries should be specifically informed about the organization's performance issues—such as through the use of a low-performing icon or other prominently displayed signal of poor performance.

We would suggest also that the BAPP measure have a relatively high weight in the star system (perhaps as high as 5, as with the improvement measure), and that if there are changes to the way the BAPP measure is computed, it should not be treated as a new measure (which would reduce its weight to 1 for the first year of the new definition of the measure).

Conclusion

The Commission appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. We also value the ongoing cooperation and collaboration between CMS and Commission 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 Mark E. Miller, the Commission's Executive Director.

Sincerely,

Francis J. Crosson M.D.

Francis J. Crosson, M.D.
Chairman