MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Jack C. Ebeler, M.P.A., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

March 5, 2009

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2010 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Ms. Frizzera:

We appreciate your staff's work on improving the Medicare Advantage (MA) and Part D prescription drug programs, particularly given the competing demands on the agency. In this letter we provide our comments on two specific issues included in the *Advance Notice of Methodological Changes for Calendar Year (CY) 2010 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies*, which CMS issued on February 20, 2009.

Coding adjustment for Medicare Advantage payment rates

CMS is proposing an adjustment to risk scores to recognize differences between the coding practices in Medicare Advantage (MA) and those in the fee-for-service (FFS) sector of Medicare. CMS proposed the adjustment on the basis of findings from the agency's analysis of differences in the growth rate of MA enrollees' risk scores compared to those of beneficiaries in FFS. CMS found that even after controlling for patient characteristics, risk scores were persistently higher for beneficiaries in MA. These higher risk scores—which result in higher MA payments—are presumed not to reflect differences in the health status of the two groups of beneficiaries, but rather differences in coding behavior.

CMS proposes to reduce MA risk scores by 3.74 percent to recognize coding differences in the period 2008 through 2010. A final adjustment figure will be announced on April 6 (the date of the publication of the notice of MA rates), once CMS analyzes additional, more recent data. CMS has specifically asked for comments on its intention to limit the adjustment period to 2008-2010.

The coding adjustment that CMS plans to undertake is consistent with the statutory requirement. When payment systems change and the amount providers or plans will be paid is affected by changes in their behavior to emphasize more coding and documentation, adjustments to the payment system are necessary to maintain the integrity and accuracy of the payment system. For example, when CMS implemented the Medicare severity diagnosis related groups (MS-DRGs), the Commission concurred with CMS on the "need for, and application of, counterbalancing adjustments to offset the effects on payments associated with improvements in medical record documentation and diagnosis coding." (See the June 10, 2008 MedPAC letter to the Acting Administrator of CMS.) Thus we support CMS's proposal to adjust MA payment rates as described in the advance notice for three reasons. It will improve payment accuracy – a principle MedPAC pursues in both FFS and MA. It will reduce unnecessary Medicare expenditures thereby protecting taxpayers and beneficiaries. And it will better assure financial neutrality between FFS and MA.

The magnitude of the proposed MA adjustment reflects the cumulative effect of the coding adjustment over the years 2008 to 2010. CMS did not make adjustments to risk scores in 2008 or 2009, even though an adjustment would have been permitted by the statute in each year. One alternative is to make an adjustment for all years during which comprehensive risk adjustment has been in place—that is, 2004 to 2010. On balance we are inclined to think that the CMS proposal is appropriate. In earlier years, the MA plans were at the beginning stages of adjusting to the new payment system (and were protected by the budget-neutral implementation) and probably lagged behind FFS in their ability to code diagnoses.

This year's advance notice indicates that the preliminary minimum update for county MA rates (which is the national growth rate for Medicare expenditures, after certain adjustments) will be 0.5 percent. The preliminary estimate assumes a substantial reduction in Medicare's payments to physicians for 2010, as required by the sustainable growth rate (SGR) mechanism. Thus, the coding adjustment creates the possibility that MA plans may see a net reduction in base payments for the coming year. However, the effect depends on the degree to which changes in coding continue to occur.

The coding adjustment should not be confused with the issue of MA benchmarks being set above Medicare FFS levels. The Commission's analysis of MA payment data and bids shows that plans payments are currently at 114 percent of FFS for similar beneficiaries. The differences in coding practices between MA and FFS that CMS has identified result in payments beyond the 14 percent by which MA payments currently exceed FFS. However, both the coding adjustment and the excess MA payments invoke payment equity (in this case between MA and FFS) and program sustainability. So as noted above we support the coding adjustment and we continue to recommend other changes to MA payments to reduce spending and reduce inequities between FFS and MA.

We are interested in CMS's plans to make coding adjustments on an ongoing basis in the future. To the extent that the statutory authority governing the agency's ability to do this is ambiguous, it would be useful for CMS to state, in the announcement of rates, how the agency is interpreting the statutory provisions and what that means for possible future coding adjustments in MA payments.

As an implementation issue, we believe that CMS should apply the coding adjustment to all MA risk scores. Making a system-wide adjustment has been the practice in past coding adjustments in other sectors of Medicare. All MA plans should be ensuring that their providers are paying close attention to coding and documentation requirements because MA payments are based on diagnosis codes, so we expect the coding changes to be widespread. The coding behavior of a particular provider in MA does not necessarily affect just one plan. It can affect more than one MA plan because many providers participate in multiple MA plans. Furthermore, beneficiaries move from one MA plan to another and retain the diagnosis codes assigned to them in their originating plan. Finally, as CMS moves towards its intended goal of using MA data (rather than FFS claims data) to determine the relative factors for risk adjustment of MA payments, a system-wide adjustment to current practices will ensure that baseline information is accurate with respect to MA expenditures and the health status of MA enrollees.

At the same time, making a system-wide adjustment should not preclude CMS from monitoring and auditing the coding practices of individual health plans (as CMS currently does) to ensure that diagnosis codes are accurate and documented.

Possible adjustment of Medicare Advantage rates because of the use of Veterans Administration facilities

As required by statute, CMS has examined whether Medicare beneficiaries' use of Department of Veterans Affairs (VA) facilities to obtain care that would otherwise be covered and paid for by Medicare has an effect on payment rates for MA plans. The absence of claims that would otherwise be paid by Medicare affects the calculation of both Medicare expenditures and the risk scores of beneficiaries in FFS Medicare (because of the lack of diagnosis codes when services are received through the VA). The resulting lack of data can result in an erroneous estimate of per capita costs for Medicare beneficiaries, which is one of the bases of payment for MA plans.

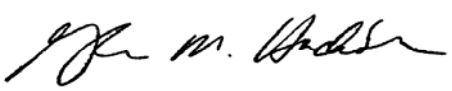
After analyzing data from the VA, CMS has concluded that no adjustment is necessary to MA payment rates. CMS did a county-by-county analysis of the VA effect, given that the impact could be greater in counties where VA facilities are available to Medicare beneficiaries. In most counties, CMS found that the difference in payment rates would be less than one dollar per person per month if the costs of care received by Medicare beneficiaries at VA facilities were included in the FFS rates. Half of counties would receive an increase and half a decrease in payments. CMS states that the differences in costs between users of VA services and non-users were "more attributable to normal, random variation than to distinctly different costs for the two populations."

A few counties did show a larger VA effect. CMS notes that, after accounting for statutorily determined minimum rates in each county, 56 counties would have a rate increase greater than $12.50 per person per month. The $12.50 amount is not a negligible amount. Because CMS has concluded that there is insufficient evidence to incorporate a VA adjustment, it would be helpful for CMS to provide more information as to why the 56 counties should not receive a rate adjustment. Specifically, is it true of these 56 counties that, as CMS has concluded, "differences observed between the two populations

appear to be normal, random variations and not indicative of true underlying differences of the FFS costs between the total and the non-veteran population"?

CMS has stated that the VA issue will be revisited in future years, with the analysis of differences undertaken again. CMS is also in the process of evaluating the effect of health care services received through the Department of Defense (DoD) as required by the statute. We look forward to CMS's continuing analysis of the VA and Department of Defense effects on MA rates. The addition of the Department of Defense data should help address the question of whether the effects are random rather than systematic differences. We believe that if counties have substantial, nonrandom differences when the VA and DoD data are analyzed, adjustments should be made to the county rates.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman