MEDPAC Medicare Payment Advisory Commission

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March 26, 2013

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Suite 314-G
Washington, DC 20201

Re: Request for comments on the 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

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission (MedPAC) is pleased to provide comments on the Centers for Medicare & Medicaid Services' (CMS's) February 15, 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. We apologize for the lateness of these comments and thank you for any attention you may give them. We appreciate your staff's work on the notice, particularly given the competing demands on the agency.

Our comments deal with several issues: treatment of the sustainable growth rate (SGR) reduction in calculating the MA growth rate for 2014, revisions to the MA risk adjustment methodology, changes to the star rating system, limitations on the total beneficiary cost calculation, and Part D tiered pharmacy networks.

Treatment of the SGR reduction as it affects MA rates

CMS projects that the MA growth rate for 2014 will be –2.3 percent, resulting in a reduction in payments for MA plans in 2014 from 2013 base payment levels. A major component of the projection is the effect of the SGR reduction in Medicare physician payments scheduled for 2014. For an element of its MA rate projections, the projection of Medicare fee-for-service expenditures in 2014, CMS assumes that the SGR cut will take effect in 2014.

Last year—and in previous years—when announcing MA payment rates, CMS had also assumed that the SGR reduction would take effect, but in each year the Congress prevented the SGR reduction from taking place. However, the SGR "fix" occurred after the date on which the final MA rates were required by law to be announced for the following year. While CMS assumes an

SGR reduction for projecting payment rates, the agency instructs MA plans to submit bids (due in June of each year) based on the assumption that SGR cuts will not go into effect.

When CMS misestimates the MA growth rate for a given year, corrections are made to that year's projections in subsequent years' projections. An upward or downward adjustment is made to reflect past years' misestimates. For example, the misestimate in 2013 rates arising from CMS's assumption of an SGR cut, which did not materialize, resulted in an upward adjustment reflected in the 2014 growth rate. However, CMS will repeat this process again in 2014—assuming an SGR reduction for 2014 and then revising rates after the fact if Congress acts to avoid the SGR reduction.

The practice of incorporating an adjustment for misestimated past projections is a statutory requirement. The requirement is particularly important because of how early the MA projections are made for the coming year, given that the final projections and the resulting MA rates are published in April. There is also a statutory provision that provides protection for MA plans when Medicare coverage rules change during the course of the calendar year. If there is a national coverage decision made during the course of the year that results in major program expenditures for Medicare, MA plans are required to provide the new coverage, but the added expenditures will be reimbursed by the FFS program. Congress enacted each of these provisions to ensure fairness in the Medicare program's relationship with private plans.

The Commission has long held the view that the SGR method for determining physician payments is flawed and should be replaced. We have made specific recommendations for a different approach, detailed in our most recent report to the Congress.[1] Each year, the Congress has forestalled full implementation of the SGR cuts, virtually at the last minute. This approach leads to confusion, uncertainty, and dissatisfaction among physicians, and if this process continues it could affect beneficiary access to care if physicians decide to leave the Medicare program or limit the number of Medicare beneficiaries to whom they provide care. In the case of MA, with over one-fourth of Medicare beneficiaries now enrolled in MA plans, it creates uncertainty in the bidding process and a situation where the plan payments have to "catch-up" year after year. The effect on MA may be an unintended consequence of the timing of Congressional action and CMS administrative actions, but it is another very real effect of the delay in action to repeal the SGR and replace it with a more rational system.

Revisions to the MA risk adjustment methodology

CMS is proposing refinements to the risk adjustment methodology for MA plans. The Commission supports efforts to improve the accuracy of risk adjustment. We have recommended ways that CMS could revise the methodology to improve its accuracy for particular classes of beneficiaries—those with multiple conditions and the chronically ill. Specifically, we suggested that the number of conditions a person has should be a component of the model and that CMS should use two years of diagnosis information to determine risk scores. The latter change would

[1] Medicare Payment Advisory Commission. 2013. Report to the Congress: *Medicare payment policy*. Washington, DC: MedPAC.

also reduce year-to-year fluctuations in beneficiary risk scores, resulting in more stable revenue streams for MA plans. CMS has not acted on either of these recommendations.

In the advance notice, CMS has proposed changes to the risk adjustment model based on updated FFS claims data, and to reflect the results of a clinical evaluation of the current hierarchical condition categories (HCCs). A number of HCCs will be added, dropped, or split apart, with the total number increasing from 70 to 79. The updated model results in differences in the relative expenditures across the 79 HCCs. Some HCCs would have lower relative expenditures compared to the prior model, and other HCCs may have higher relative expenditures for individuals in that HCC category.

At the level of the individual MA plan, the proposed change can result in a lower or higher average risk score for the plan's enrolled population. However, CMS notes that across all MA enrollees, the proposed changes will result in a lower average risk score in MA in 2014 than in 2013—meaning that plan revenue will decline on average across the entire MA population (all other things equal). CMS proposes to compensate for what would otherwise be reduced plan revenue by incorporating an adjustment factor that will raise the average risk score across all plans so that the 2014 average risk score in MA will be at the 2013 level. CMS suggests that one reason for the difference in average MA risk scores between 2013 and 2014 is that some of the HCCs with relative values that are being reduced are the HCCs that tend to reflect more intensive coding in MA in relation to FFS. CMS specifically stated that it "made changes to several other HCCs to address MA coding intensity."

Although we support continuing refinement of the risk adjustment methodology to improve its accuracy, a change that is essentially a coding adjustment should be addressed through the separate mechanism that CMS has used to make coding adjustments for MA plans. The Commission supports CMS's efforts to address the problem of higher coding intensity in MA compared to FFS, and a specific adjustment—applied across all MA plans—is now incorporated in statute. For 2014, CMS is using the minimum specified coding adjustment rate required by statute, but it may, at its discretion, apply a higher coding adjustment. Any adjustment arising from CMS's revisions to the HCC which are due to coding differences between MA and FFS should be evaluated and addressed as a coding issue rather than as a payment adjustment due to changes in the HCC model.

Changes to the quality star rating system

In general we support the proposed changes to the star rating system announced in the call letter—which reflect CMS's continued efforts to improve the star system through consultation with stakeholders—outlined in the call letter. One proposal, which would change how overall plan star ratings are calculated, has drawn particular attention from the industry. In the proposed methodology, the actual numeric scores that a plan receives for each quality measure would be averaged to produce an overall plan star rating; currently, each measure receives a star rating (from 1 to 5), and the overall plan star rating is the average of the star ratings assigned to individual measures. For example, for the breast cancer screening measure, a plan receives a 4-star rating if the rate is greater than or equal to 74 percent but less than 83 percent. The new methodology would use the actual rate for averaging purposes (for example, 83 percent at the high end, and 74

percent at the low end of the breast cancer screening rate, rather than using a 4-star rating for the individual measure for both the high and low end of the actual rate).

Before implementing the new averaging approach, CMS should provide information about the anticipated effect of the methodology; the agency should also consider delaying the change until next year.

Limitation on the total beneficiary cost calculation

The Commission also has concerns about the limitation on the total beneficiary cost (TBC) calculation. The TBC is intended to protect beneficiaries in their current plans from large changes in cost liability. The Commission agrees that plan bids have to be carefully reviewed to ensure that beneficiaries are not unfairly affected by changes in plan bids. However, the Commission believes that the methods for calculating the TBC should be reviewed. Changes in the cost of delivering Medicare services may require plans to revise their benefit and premium offerings, and beneficiaries will respond accordingly—by staying with the plan, moving to a less expensive plan, or moving to FFS. Plans should have flexibility to tailor their offerings as their costs change.

That said, the Commission reiterates its point that CMS needs to be vigilant about excessive changes in beneficiary cost liability aimed at discouraging selected beneficiaries from enrolling in particular plans. Additionally, CMS will have to ensure that plans clearly communicate changes in premiums and cost sharing so that beneficiaries have the information they need to make decisions during open enrollment.

Part D tiered pharmacy networks

In our most recent report to the Congress,[2] we reported an increase in sponsors' use of tiered pharmacy networks that distinguish between preferred and nonpreferred pharmacies among the pharmacies that are classified as in network. Cost sharing (copayments and/or coinsurance) for beneficiaries in plans with preferred networks is less for preferred pharmacies than for nonpreferred pharmacies, with varying degrees of cost-sharing differentials across plans.

The draft CY 2014 call letter reminds Part D sponsors that, although the use of lower cost sharing at some network pharmacies is permitted, such cost sharing reductions are permissible only if the reductions do not increase CMS payments to these plans. The findings of higher unit costs observed among preferred pharmacies combined with lower cost sharing offered at these pharmacies may suggest that these plans are in violation of this requirement. Thus, the agency notes the need to further scrutinize Part D drug costs in PDPs with preferred pharmacy networks.

We appreciate the agency's concern and agree with its actions to ensure that competition is resulting in lower costs for the program and for the enrollees. The Commission shares those objectives and would also raise concerns about the effects these tiered pharmacy networks have on program costs and on beneficiaries. One question we raise is: What factors are driving sponsors to

[2] Medicare Payment Advisory Commission. 2013. Report to the Congress: *Medicare payment policy*. Washington, DC: MedPAC.

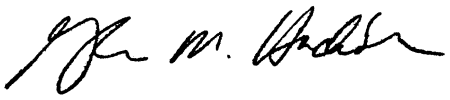
offer lower cost sharing at preferred pharmacies if the lower cost sharing is not the result of lower payments for drugs at preferred pharmacies compared with those at nonpreferred pharmacies, as was suggested from the findings from CMS's initial analysis?

The Commission is also concerned that not all pharmacies in a plan's service area are offered the opportunity to join the preferred pharmacy network. If the use of tiered pharmacy networks is driven by lower costs, allowing any willing pharmacy that accepts the terms and conditions to participate as a preferred pharmacy should provide more opportunities for Part D's competitive structure to drive lower prices for the program and its enrollees.

Given the rapid increase in the number of plans that use tiered pharmacy networks, the Commission will continue to monitor the effects of this trend to ensure that program costs and beneficiary access are not adversely impacted.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth
Chairman