MEDPAC Medicare Payment Advisory Commission

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March 5, 2010

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) 2011 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2011 Call Letter

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 three specific issues included in the *Advance Notice of Methodological Changes for Calendar Year (CY) 2011 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2011 Call Letter*, which CMS issued on February 19, 2010.

## Coding adjustment for Medicare Advantage payment rates

In the Advance Notice, 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 differences in the growth of risk scores in MA compared to FFS. The agency's analysis compared the growth in risk scores of a fixed cohort of MA enrollees over a three-year period compared to a similar cohort of beneficiaries in FFS. CMS found that even after controlling for patient characteristics, risk scores increased more for beneficiaries in MA than those in FFS. 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.

For calendar year 2011, CMS proposes to reduce MA risk scores by 3.41 percent to recognize coding differences in the period 2008 through 2010. The agency reduced risk scores in 2010 by the same amount and MedPAC supported this approach. (See the

March 5, 2009 MedPAC letter to the Acting Administrator of CMS.) Note, the 2011 adjustment is not additive to the 2010 adjustment.

The coding adjustment that CMS proposed is consistent with the statutory requirement in section 1853(k)(2)(B)(iv)(III) of the Social Security Act, which requires CMS make an adjustment to reflect "differences in coding patterns between Medicare Advantage plans and providers under part A and B..." When payment systems change and providers or plans have financial incentives to improve coding and documentation, payment adjustments 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. It will improve payment accuracy—a principle MedPAC pursues in both FFS and MA. Additionally, it will reduce unnecessary Medicare expenditures, thereby protecting taxpayers and beneficiaries.

In the Advance Notice, CMS requested comments on its proposal, specifically whether to base the adjustment on three years of plan coding differences or to add an additional year of data to the adjustment model. In the interest of improving payment accuracy and monitoring the potential continued differences in coding behavior between MA and FFS, we encourage CMS to calculate the adjustment taking into account changes in risk scores over four years, instead of limiting the adjustment to a three-year period. Furthermore, we would like to see CMS update the factor each year, just as they update the risk-adjustment model's normalization factors each year.

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 continue to exceed FFS payments for similar beneficiaries. So as noted above we support the coding adjustment and we continue to recommend changes to MA payments (See MedPAC March 2010 Report to Congress, *Medicare Payment Policy*.)

## Adjustment to FFS Per Capita Costs for VA/DOD costs

As required by statute, CMS has examined whether Medicare beneficiaries' use of Department of Veterans Affairs (VA) or Department of Defense (DoD) 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.

Last year, CMS stated 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." This year, CMS obtained data from the DoD and concluded that there were not significant differences in cost between users of DoD services and non-users in most of the 3,000 counties they analyzed. However, they did find differences for DoD users enrolled in the Uniformed Services Family Health Plan (USFHP). Therefore, CMS will adjust the FFS rates in the 138 counties with 10 or more Medicare beneficiaries who are also enrolled in the USFHP. The average county FFS rate adjustment would be approximately $1.85 per month. The adjustments will range from a decrease of $0.10 to an increase of $12.04.

This adjustment is consistent with MedPAC's position that FFS county rates, which feed into the MA benchmarks, should reflect the patterns of service utilization by FFS Medicare beneficiaries. The agency's analysis of VA and DoD claims clarifies these patterns. Therefore, MedPAC supports the adjustment.

## Recalibration and Clinical Update of the RxHCC Risk Adjustment Model

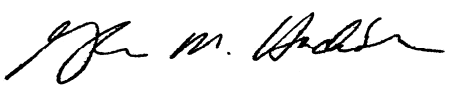
The 45-day notice describes CMS's recalibration and clinical update of the prescription drug hierarchical condition category (RxHCC) model for risk adjusting Part D plan payments in 2011. In past years, the Commission has expressed concern about the performance of Part D's risk adjusters; specifically, RxHCCs with multipliers for low income and long-term institutionalized status. We have been concerned that if risk adjusters do not compensate plan sponsors adequately for enrollees who receive Part D's low-income subsidy (LIS), there could be an incentive for sponsors to bid higher to avoid LIS enrollees—especially if non-LIS enrollees were not very sensitive to rising premiums. Commission-sponsored analysis suggested that for a large but non-representative sample of stand-alone prescription drug plans (PDPs), ratios of actual plan benefit spending for LIS enrollees compared with non-LIS enrollees were considerably higher than the amounts suggested by CMS's multipliers. When researchers added prior-year drug information to RxHCC scores in their analysis, CMS's multipliers performed better.

For 2011, CMS has proposed a different approach. The agency plans to replace a single base model of risk scores and multipliers with five separate sets of coefficients: for long-term institutional, aged low income, aged non-low income, disabled low income, and disabled non-low income enrollees. We think this approach shows promise for improving the performance of RxHCCs and could provide greater incentive for sponsors to compete for LIS enrollees through their plan bids. CMS told Commission staff that in prior years, they believe the combination of risk scores with multipliers performed well on average, but that it under-predicted costs for younger disabled enrollees and over-predicted costs for elderly low-income enrollees. Five separate sets of risk-adjustment coefficients may better capture differences in the mix of prescription drugs taken by, for example, younger dual-eligible beneficiaries with conditions such as HIV/AIDS or with serious mental

illnesses compared with elderly beneficiaries who take medications for diabetes and heart disease.

As CMS begins to use the new RxHCC model, at least two areas warrant close attention. First, we expect that payments for long-term institutionalized enrollees will increase. Commission-sponsored research suggests that prices for drugs used by institutionalized beneficiaries in Part D have grown more rapidly than have prices for other Part D enrollees. While there are legitimate reasons for prescription costs to be higher in long-term care settings, ideally prospective Part D payments will continue to give sponsors incentives to manage growth in the drug spending of all enrollees. In a similar vein, the Commission has noted higher spending and lower use of generic drugs by LIS enrollees. We have begun examining the extent that higher spending stems from differences in health status, lower cost sharing paid by LIS enrollees, and other factors. In its updated approach to risk adjustment, CMS is paying plans more for LIS enrollees based on their higher average costs to plans. It may be useful to look for examples of Part D plans that are doing a better job of providing needed medications and still managing the drug spending of their LIS enrollees, so that we can encourage similar techniques among other plans.

Sincerely,



Glenn Hackbarth