

# **Comments on Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017**

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*December 18, 2015*

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## Introduction

This public document contains comments submitted by the Medicare Managed Care industry and other industry representatives in response to the October 28, 2015, HPMS memo, *Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017*. The document includes the names of the submitting organizations and the verbatim comments. The document excludes header and footer information, contact information, contract information, greetings and salutations, submitters' signatures, and all comments submitted after the November 25, 2015 deadline.

### 1. Aetna

Aetna appreciates the opportunity to submit comments on the proposed changes to the CMS-HCC Risk Adjustment Model for payment year 2017. Aetna is one of the nation's leading diversified health benefit companies and is committed to working with the Centers for Medicare & Medicaid Services (CMS) to formulate reimbursement rules and policies that advance what we believe serve Medicare beneficiaries' priorities: affordability, competition and choice, and access. In that spirit, we have the following comments regarding CMS' proposed changes to the risk adjustment model.

1. Focus on the central issue—the model's predictive imbalance between full and partial dual eligibles—and refrain from adjusting the currently successful model for non-duals.

In response to concerns about the accuracy of the risk adjustment model for predicting costs of dual eligible beneficiaries, CMS is assessing how well the model performs for these beneficiaries. CMS' assessment is that "the model predicts accurately overall" based on a fee-for-service population.

Specifically, CMS found that the 2014 model under predicts the actual cost of full benefit dual eligible beneficiaries (the predictive ratio was 0.914 for full benefit dual eligible beneficiaries, where 1.0 would be a perfect prediction). At the same time, the 2014 model over predicts the actual costs of partial benefit dual eligible beneficiaries by a similar margin (predictive ratio was 1.092).

In contrast, CMS found that for the non-dual eligible population—which is the vast majority of Medicare beneficiaries—the current risk adjustment model's predictive ratio was 1.015. In other words, while the current model only slightly over predicts costs for the non-dual fee-for-service population, it is in CMS' view, "fairly accurate." Therefore, based on this, this is no justification for changing the model with respect to non-dual eligibles.

As a result, CMS has discovered the primary weakness in the risk model for dual eligibles: the current model does not properly reflect the expected costs between the full and partial dual eligible populations.

Aetna supports CMS' efforts to develop a more accurate risk adjustment model to reflect the disproportionate costs expected to be incurred by dual-eligible individuals. We additionally believe it is important that the risk adjustment program accurately predict the costs of the dual eligible population, because that population accounts for approximately one-third of Medicare spending, while accounting for approximately one-fifth of the overall beneficiary population. An accurate risk adjustment model will strengthen the success of dual eligible plans.

However, while we support accurate risk prediction for dual eligible beneficiaries, we recommend that CMS limit its revisions to addressing the demonstrated weaknesses in the 2014 model—specifically, the

over prediction of costs for partial dual eligible and the under prediction of costs for the full dual eligibles. We recommend this approach rather than CMS developing a model that segments the community population into six separate groups, all of which—including non-duals—are subject to the new risk model. Instead, CMS should simply rebalance the model to accurately reflect the costs between full dual eligibles and partial dual eligibles.

Adjusting the model for non-dual eligible beneficiaries unnecessarily (and unfavorably) disrupts the largely accurate model and adds unnecessary complexity as it is applied to non-dual eligible beneficiaries, unsettling Medicare Advantage issuer forecasting and pricing for the majority of their plans, and may have a disruptive impact on the Medicare Advantage market.

Aetna is also concerned about the accuracy of the current “default” risk scores and the effect that imposing the new risk adjustment model on already inaccurate default risk scores will have. For example, we believe that the current default non-dual risk score is too low, because it understates the average disease burden for new non-dual age-in beneficiaries. These beneficiaries may have an assigned default risk score for longer than 12 months in some cases, and this inaccuracy in the risk adjustment model could have a significant adverse impact on Medicare Advantage plans. If the proposed new model applies to non-duals and has the effect of adjusting the risk scores of non-duals downward, it will further decrease the accuracy of the risk score model with respect to non-dual members assigned default scores. CMS could avoid this result by not adjusting the current risk adjustment model as applied to non-duals. It could further mitigate any adverse impact of an inaccurate default score by limiting the length of time any beneficiary—non-dual, partial dual, and full dual—is assigned a default score until HCCs emerge.

In addition, while Aetna appreciates that CMS has provided stakeholders with how it intends to adjust the risk adjustment model generally, the actual factors that will be used in the model will not be available to Medicare Advantage plans until the 45-day Advance Notice is released. This means that issuers will have only two weeks to evaluate and provide comments on the specific changes to the model factors. In order to provide the most accurate and helpful analysis and comments, CMS should release the factors earlier, or provide a longer period of time for stakeholders to comment on them.

**Recommendation:** Revise the model only to accurately reflect the costs between full and partial dual eligible beneficiaries and refrain from adjusting the currently successful model for non-duals. Provide adequate time for stakeholders to evaluate and comment on proposed changes.

2. Normalize the different distribution of risk between fee-for-service beneficiaries and Medicare Advantage beneficiaries.

We encourage CMS to examine the “normalization” between fee-for-service beneficiaries and Medicare Advantage beneficiaries. There are differences between the fee-for-service Medicare beneficiary group and the Medicare beneficiaries that choose to enroll in a Medicare Advantage plan. These differences may have a material effect on the relative risk of each group (e.g., there may be a different distribution of individuals that are dual eligible in one group than in the other).

As recommended in Section 1 above, Aetna does not believe that CMS should change the model for non-dual eligible beneficiaries. Unnecessarily adjusting the non-dual model is of particular concern if the fee-for-service data upon which the model is based does not accurately reflect the costs of the typical non-dual beneficiary enrolled in a Medicare Advantage plan.

**Recommendation:** CMS should normalize the different risk distribution between fee-for-service Medicare beneficiaries and Medicare Advantage beneficiaries. Once CMS has normalized the

distribution, it should publish the normalization so that Medicare Advantage plans may review and comment on it.

3. Appropriately reflect costs associated with gender between dual eligible and non-dual eligible beneficiaries. The current model includes demographic variables including age, gender, disabled status, original reason for entitlement and Medicaid eligibility. However, it is unclear if CMS' proposal uses the same gender adjustment for dual and non-dual beneficiaries.

**Recommendation:** Confirm that a separate gender adjustment for dual eligible individuals and non-dual eligible beneficiaries is proposed. In order to develop a revised risk adjustment model that more accurately reflects the expected costs of community-based dual eligible beneficiaries than the current model, CMS should include a separate adjustment for gender because it is an important variable that could have significant effects on the accuracy of the model.

4. Provide access to the MMA Medicare/Medicaid Dual Eligible monthly file. CMS is proposing that dual status will be determined concurrently; that is, CMS will determine appropriate risk scores for each monthly payment based on a beneficiary's status in that payment month. While similar to how CMS determines Community and Institutional status, this proposal is different from how CMS currently determines dual status.

Although not clear in the proposal, we assume that CMS will use the MMA Medicare/Medicaid Dual Eligible monthly files as the source of Medicaid status for the risk score, because all states provide these files monthly which identify beneficiaries who are dually eligible for both Medicare and Medicaid and are considered the most current, accurate and consistent source of information on dual-eligible beneficiaries.

Aetna is concerned that there may be significant operational challenges with this proposal. For example, it is unclear how CMS proposes to address retroactive eligibility determinations—a common occurrence for the dual eligible population. We recommend that CMS provide additional details to stakeholders on how its proposal to update dual status monthly will work, with the opportunity for interested parties to comment.

If CMS finalizes the proposal to determine dual status monthly, Aetna recommends that CMS provide access to the MMA Medicare/Medicaid Dual Eligible monthly files to Medicare Advantage plans. Access to this data will provide more accurate information to Medicare Advantage plans, which will allow a plan to more accurately adjust its financial forecasting, and provide more accurate data for future year rate setting. Providing access to this data is particularly important because Medicare Advantage plans have no historical data available to anticipate the fluctuations in risk scores that might result from reassessing dual eligible status monthly. In addition, we recommend that CMS restate last year's risk scores based on the proposed monthly dual status changes so that Medicare Advantage plans have a better understanding of how this proposed change will affect the aggregate risk score payments.

We are also concerned that eligibility determination can be retroactive as much as 90 days. For monthly determination of eligibility, this could result in having to make multiple revisions to beneficiaries' eligibility status. One way to mitigate this would be to lag the eligibility determination by 90 days, so that the information used would capture retroactive determinations.

**Recommendations:**

- Provide additional details to stakeholders on how monthly dual status determinations will work, and provide opportunity for feedback;

- Provide access to the MMA Medicare/Medicaid Dual Eligible monthly files to Medicare Advantage plans;
- Lag dual status eligibility data by 90 days to allow recognition of retroactive determinations.

## **2. Alliance of Community Health Plans (ACHP)**

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to comment on the “Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017,” published on October 28, 2015.

ACHP is a national leadership organization representing community-based and regional health issuers and provider organizations. ACHP’s member health plans provide coverage and care for more than 18 million Americans. Our members are not-for-profit health plans or subsidiaries of not-for-profit health systems; most cover substantial numbers of Medicare Advantage (MA) enrollees. Eight of the 12 MA plans with a 5-star rating are offered by ACHP members. Our member plans share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality.

ACHP appreciates and supports CMS’ efforts to improve the accuracy of the HCC risk adjustment model to predict costs across all populations, including specialized populations such as dual eligible enrollees. We support implementation of the proposed changes for dual eligible SNPs (D-SNPs) in 2017, but we recommend that CMS hold off on incorporating the changes for non-dual MA plans until the next time that the HCC risk adjustment model is recalibrated.

There is precedent for adopting different risk adjustment models for specialized populations. CMS currently risk adjusts PACE MA plan with a different version of the HCC risk adjustment model. In addition, CMS uses a separate and distinct ESRD HCC risk adjuster model for the ESRD members enrolled in MA plans because of the unique nature of ESRD beneficiaries.

Duals enrolled in MA plans are also a “specialized” population from other perspectives that make it reasonable to implement a separate risk adjuster in the next plan year. The bidding process is different for D-SNPs given their benefit design and premiums and the necessary coordination with state Medicaid programs. In many situations, MA plans also have different provider networks for their duals, particularly for their full benefit duals. For these reasons, we support 2017 implementation of the proposed changes in the CMS-HCC model for D-SNPs.

ACHP recommends that CMS not implement the risk adjustment change in 2017 for non-dual MA plans. Several changes in the CMS-HCC model are already taking place, introducing a significant element of uncertainty. These include full implementation of the 2014 clinical model and the transition to ICD-10 coding. We also believe there are administrative challenges in moving to the proposed changes that CMS and plan sponsors need time to work through; these are summarized below. We suggest that CMS wait until the next recalibration of the CMS-HCC model and include this proposed change to the risk adjustment calculation at that time.

### **Implementation Issues**

- There is often significant retroactivity for Medicaid beneficiaries moving in and out of Medicaid status, and even moving among the different categories of Medicaid status, e.g., QMB Plus to QMB or SLMB Plus to SLMB. Changing Medicaid status to be concurrent with the payment year



will make it even more important for CMS (and the states) to provide the correct status indicator each month in a timely manner and CMS will need to be prepared to handle significant retroactivity in payment adjustments.

- State information regarding the Medicaid status of MA beneficiaries is likely not to be of equal quality across all states. We urge CMS to work with states to make sure that they are able to supply CMS and plan sponsors timely information on dual status, particularly between full and partial benefit duals if CMS moves to separate full and partial dual status.
- CMS will have to ensure that MA plans receive timely membership and payment reports with the new dual categories so that plans can reconcile CMS payments. This would mean updating the MMR to make sure the new dual categories are incorporated into the MMR report in a timely manner.
- If CMS decides to implement the updated model across all MA plans, we urge CMS to make available the new model's coefficients and relative factors at the time of the release of the Advance Payment Notice, so that plans can estimate the new model's impact across all of their MA plans. Given this significant change, it will be important that CMS give MA plans, particularly non-dual plans, an estimated risk score by plan under the new model by early April 2016. Plans will need this information so that they can correctly forecast risk scores for their 2017 bids.

### **Using Concurrent Medicaid Status**

ACHP supports the proposed use of concurrent (payment year) information about an enrollee's Medicaid status, rather than prior year as is done under the current model. Given the frequent number of changes in Medicaid status in a year, using concurrent information provides the most accurate indicator of status for the risk adjustment calculation.

ACHP encourages CMS to consider other uses of concurrent information in predicting costs for a payment year. In particular, we think that CMS should adopt a concurrent HCC risk adjuster for age-ins and new enrollees – the fastest growing population in the Medicare program – rather than simply using demographic factors. A similar change should also be made for enrollees with certain high cost diseases, e.g., pancreatic cancer, for which expected lifespan is often not beyond a year.

### **Potential Impact on Overall MA Revenue**

Finally, we are concerned that the proposed change to the model may result in an overall decrease in the amount of revenue available for the Medicare Advantage program. CMS has indicated that it would adjust rates downward by 1.5 percent for every 3 non-dual beneficiaries in order to increase rates by 4.3 percent for each dual eligible beneficiary. According to CMS, this would achieve revenue neutrality across the fee-for-service population. However, the ratio of non-duals to dual eligibles across all MA plans is far higher than this approximately 3-to-1 ratio. This suggests that the decrease in revenue for non-duals will not be fully offset the increase in revenue for duals across all plans collectively, resulting in a net loss in revenue for the MA program. We ask that CMS incorporate an adjustment so that the proposed changes to the CMS-HCC model are implemented in a revenue-neutral manner – that is, with no further loss of funding available to MA plans taken together.

### **Conclusion**

ACHP appreciates that CMS has responded to concerns and developed these proposed changes to the upcoming 2017 CMS-HCC Risk Adjustment model. We applaud CMS' commitment to transparency and continue to believe that CMS should develop additional mechanisms to allow experts from among MA

plans to share concerns and analyses, and offer recommendations, as CMS continues to consider changes to the risk adjustment model and other payment policies.

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### **Full v. Partial Dual Eligibles**

Given the very small segment of the MA population that is full benefit dual eligibles, ACHP encourages CMS to review whether separating full and partial duals adds much additional accuracy to the MA Program. Given the difficulty of plan sponsors to offer MA coverage to full benefit duals, and the complexity of adding an additional category of the full benefit duals to the model – and, at the back end, the complexity of implementing a whole new category to risk adjusted payments – we suggest that CMS should make sure there is enough of a statistically significant cost differential between the two populations to warrant the separation of duals into two distinct risk adjustment categories.

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### **Conclusion**

ACHP appreciates that CMS has responded to concerns and developed these proposed changes to the upcoming 2017 CMS-HCC Risk Adjustment model. We applaud CMS' commitment to transparency and continue to believe that CMS should develop additional mechanisms to allow experts from among MA plans to share concerns and analyses, and offer recommendations, as CMS continues to consider changes to the risk adjustment model and other payment policies.

### 3. Altegra Health

On behalf of Altegra Health, I am pleased to submit our comments on the memo from the Health Plan Management System (HPMS), "Proposed Changes to the CMS-Hierarchical Condition Category (HCC) Risk Adjustment Model for Payment Year 2017," dated October 28.

Altegra Health applauds CMS's recognition that the existing CMS-HCC model under-predicts the health care costs of full-benefit dual eligible Medicare Advantage (MA) beneficiaries and we fully support CMS's efforts to more accurately compensate MA plans for the care of these beneficiaries. However, we are concerned that the changes CMS proposes to the partial-benefit dual eligible model could have the unintended consequence of reducing enrollment in Medicare Savings Programs (MSPs), which help low-income MA beneficiaries pay Medicare premiums and cost-sharing. The Medicare Payment Advisory Commission (MedPAC) has expressed concern about the low percentage of eligible individuals who are aware of and enroll in these critical programs. While MA plans are allies in CMS's efforts to increase enrollment in MSPs, reducing MA plan payments for partial-benefit dual eligible beneficiaries would reduce resources for MA plans to help these beneficiaries enrollment in MSPs. Therefore, we urge CMS to improve the accuracy of plan payments for full-benefit dual eligible beneficiaries, while preserving current payment levels for partial-benefit dual eligible beneficiaries.

This letter provides background information on MSPs and Altegra Health's role in helping MA low-income beneficiaries learn about and enroll in MSPs, as well as the harm to these efforts that could occur if CMS moves forward with its proposal to reduce payments for partial-benefit dual eligible beneficiaries.

In addition to Altegra Health's role in MSP eligibility, Altegra Health provides risk adjustment services to MA plans and therefore we also include technical and operational suggestions with respect to the proposed changes in the model.

#### **Background on Altegra Health**

Altegra Health provides risk adjustment, quality, government program assistance, and advisory services to more than 150 MA, Medicaid, and commercial plans operating in all 50 states, as well as the District of Columbia and Puerto Rico. We also serve hospitals, Accountable Care Organizations (ACOs), and other healthcare providers.

The mission of Altegra Health is to help healthcare organizations and their members receive the financial resources and other benefits to which they are entitled, enabling quality care at the right time, leading to improved health at a lower cost, and overall, a better quality of life. Altegra Health utilizes health plan data and Altegra Health's proprietary predictive analytics algorithms to assist health plans in delivering integrated health-related interventions that are specifically tailored to their members. In carrying out this mission, Altegra Health is committed to maintaining the strictest regulatory compliance and data security for health plans and the members that they serve.

#### **Concerns about MSP Participation**

Low-income Medicare beneficiaries whose income or assets exceed state thresholds for full Medicaid benefits may be eligible for MSPs that help pay their Medicare premiums and cost-sharing. Eligibility criteria and benefits vary across the four MSPs (Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), Qualified Disabled and Working Individuals (QDWI)). The Congressional Budget Office has estimated that only 33 percent of those eligible for the QMB program have enrolled, and only 13 percent of those eligible for the SLMB program

have enrolled. 2 MedPAC, as well as the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC), have studied the issue and believe low participation may be due to lack of awareness of MSPs, the complexity of the application process for beneficiaries, and that the eligible population is hard to reach because of age, linguistic barriers, isolated location, or cognitive impairment.

Low MSP participation concerns Congress, which has twice taken steps to address it, including by requiring the Social Security Administration (SSA) to notify low-income Medicare beneficiaries that they may be eligible for MSP benefits and by requiring SSA to transfer information about potentially eligible beneficiaries to the relevant state Medicaid agencies.

### **Altegra Health's Role in Promoting MSP Participation**

Current CMS payment policies encourage MA plans to identify those beneficiaries that are eligible but not enrolled in a MSP and help them obtain the benefits to which they are entitled. Many MA plans contract with Altegra Health to perform this important work. The low enrollment figures for MSPs demonstrate how critical it is to have resources dedicated to facilitating these enrollments.

Altegra Health uses a proprietary predictive analytics model to determine the likelihood that MA low-income beneficiaries will be eligible for MSP. Altegra Health's model has historically been extremely successful in identifying these beneficiaries, with an accuracy rate consistently over 95 percent. After applying its predictive analytics, Altegra Health outreach staff helps these beneficiaries submit their enrollment applications. Altegra Health reaches out to these beneficiaries through mailings and phone calls to educate them about MSP and its benefits.

Interested low-income MA beneficiaries can then choose to utilize Altegra Health's My Advocate™, an internet-based eligibility screening tool that helps these beneficiaries enroll in these programs. An Altegra Health outreach worker can also walk the beneficiary through the MSP application and assist with every step necessary to complete it. The beneficiary can choose to designate Altegra Health's outreach staff as his or her authorized representative in order to submit the application on his or her behalf and address any issues that surface as the application is evaluated by the state Medicaid agency.<sup>5</sup> Finally, Altegra Health reaches out to enrolled MSP beneficiaries annually to assist with the renewal of their MSP benefits if they still qualify.

Altegra Health devotes significant resources to understanding the MSP eligibility criteria and process in each state. As the enrollment figures show, without this experienced adviser, enrollment in these programs can be challenging. In 2014, Altegra Health helped more than 50,000 MA low-income beneficiaries enroll in MSP. Overall, Altegra Health has helped beneficiaries secure \$1.9 billion in Part B premium savings.

Altegra Health also links MA low-income beneficiaries with other programs from which they may benefit such as the Part D Low Income Subsidy (LIS) and can help them apply. Altegra Health's COMMUNITY Link™ product can help beneficiaries learn about and enroll in more than 10,000 public and privately-sponsored community programs, including for nutritional and energy assistance. These benefits positively impact a beneficiary's overall health and well-being. Furthermore, we have seen that beneficiaries receiving MSP, LIS, or community and social supports are more likely to be satisfied with their MA plan and the Medicare program.

### **Comments on the Proposed Changes to the Risk Adjustment Model**

*Impact on Payments for Full-Benefit Dual Eligible Beneficiaries*

Altegra Health fully supports CMS's commitment to improve payments to plans that enroll full-benefit dual eligible MA beneficiaries. CMS's own analysis shows that the current CMS-HCC model predicts only 91.4 percent of the actual cost of full-benefit dual eligible beneficiaries. Dual eligibles account for 34 percent of Medicare spending, despite consisting of only 20 percent of the Medicare population.

Management of the chronic and acute care needs of this population is a key to improving care, population health, and reducing costs. MA plans can be partners in this effort but they will lack the resources to do so if they are being paid only 91.4 percent of the cost of providing care.

#### **Impact on MSP Enrollment Efforts**

Altegra Health believes that reducing payments to MA plans to enroll partial-benefit dual eligible beneficiaries into MSPs will adversely impact these beneficiaries. At a time when Congress, MedPAC and MACPAC have expressed serious concerns about the accessibility of MSP, reducing plan payments for this population would further reduce enrollment by discouraging MA plans from conducting the resource-intensive outreach and assistance necessary to help their beneficiaries obtain these benefits. Without these critical plan payments, potential MSP beneficiaries will needlessly face higher Medicare premiums and cost-sharing, likely resulting in fewer resources for beneficiaries to use on essential items such as food, rent, or other healthcare costs. They may also forego needed medical care as a means to avoid deductibles and other cost-sharing obligations in the absence of MSP enrollment.

Maintaining payments for partial-benefit dual eligible beneficiaries is critical to ensuring that these beneficiaries have access to the care and resources they need to remain healthy. Given the relatively small proportion of low-income seniors and people with disabilities who are partial-benefit dual eligible beneficiaries, the financial impact on the Medicare program as a whole of maintaining current payment levels should be relatively small. Additionally, preserving payments will have an immediate and significant impact on the lives of these beneficiaries.

Finally, in the current payment model, the additional incremental cost of caring for partial-benefit dual eligible beneficiaries and assisting them in the MSP eligibility process is captured in the Medicaid add-on factor, whereas in the revised model, we understand that population-specific costs would be captured entirely in HCC coefficients. Altegra Health is concerned that this shift to an HCC-driven model will reduce overall payments resulting from uneven and inadequate risk scores. Risk scores are dependent upon provider documentation and billing and health plan data submission via the Risk Adjustment Processing System (RAPS) and the Encounter Data System (EDS). Insufficient documentation or data submission errors can reduce risk scores, which will now affect the adjustment for Medicaid status. The CMS analysis could not account for this factor since fee-for-service (FFS) data was utilized. To compensate, MA plans will need to invest additional resources to identify and correct inadequate risk scores. This potential decreased payment and additional expense may further reduce resources for MA plans to identify and enroll beneficiaries in MSPs and LIS.

#### *Operational and Technical Comments*

Waiting until the 2017 Advance Rate Notice in February to release the revised CMS-HCC model does not give MA plans sufficient time to analyze the impact of the revised model and give CMS meaningful feedback. Furthermore, MA plans need significant advance notice of changes to the CMS-HCC model in order to correctly prepare their bids. Altegra Health encourages CMS to release the full model as soon as possible, and to include the SAS code in this release, as CMS has done for the commercial risk adjustment model. Direct access to the SAS code will reduce the time it will take MA plans to evaluate

the impact of the change, allowing CMS to receive meaningful comments and bids that are priced accurately.

Because CMS proposes to move to a concurrent model, the model will need to address additional eligibility issues. Altegra Health's experience enrolling and re-enrolling MA low-income beneficiaries have shown that there is significant variability in the amount of time state Medicaid agencies take to process beneficiary applications. CMS should review its proposed changes to ensure that MA plans are paid accurately for the months that a beneficiary is enrolled in a MSP, particularly when an application is processed with retroactive benefits and there is a delay in the data reaching CMS from the state. We recommend that CMS create clear tracking for payment adjustments and allow for the possibility that payment adjustments could occur after the final sweeps deadline resulting from Medicaid retroactive status and delays in state reporting.

CMS should clarify whether it intends to make any changes to the payment timing for the Institutional, End-Stage Renal Disease (ESRD) and New-to-Medicare models. Specifically, CMS should clarify whether these models will continue using the current Medicaid add-on factor with base payment derived from the base year rather than the concurrent year. If so, we are concerned that managing payments for two different methodologies could be very complicated, especially because beneficiaries can move between the models. Therefore, we recommend that CMS adjust the payment methodology to be consistent for all risk models, either prospective or concurrent.

The October 28 HPMS memo does not explain how the revised model will account for MA enrollees without HCCs; Altegra Health encourages CMS to explain.

### **Conclusion**

Altegra Health appreciates the opportunity to share its experience helping MA low-income beneficiaries enroll in MSPs. We urge CMS to consider the impact of changes to the HCC model that will result in reduced resources to help these beneficiaries gain access to programs to which they are entitled. Please feel free to reach out to me or our team if we can be of further assistance.

## **4. Alzheimer's Association**

The Alzheimer's Association appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Proposed Changes to the CMS-Hierarchical Condition Category (HCC) Risk Adjustment Model for Payment Year 2017.

The Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Today, there are more than 5 million Americans living with Alzheimer's disease. Alzheimer's is the sixth leading cause of death in the United States, and the only cause of death among the top 10 without a way to prevent, cure, or even slow its progression. In 2015, the direct costs to American society of caring for those with Alzheimer's will total an estimated \$226 billion, including \$153 billion in costs to Medicare and Medicaid.

Nearly one in every five dollars spent by Medicare is on people with Alzheimer's or another dementia. In 2050, it will be one in every three dollars. Thus, we strongly encourage CMS to consider the following comments to improve both payment accuracy and care for this growing population of beneficiaries.

CMS proposes to alter the current risk adjustment model applied to Programs of All-Inclusive Care for the Elderly (PACE) and Medicare Advantage plans. We applaud CMS's efforts to improve the model's predictive ratios with the proposed six community segments. We are concerned, however, about the proposed use of some elements of the 2014 CMS-HCC model. Specifically, we are concerned by the

omission of dementia-related HCC codes from the 2014 model, and consequently, the model proposed for 2017.

Omission of dementia-related HCC codes from risk adjustment significantly reduces the predictive ratio of the model. Because PACE organizations serve so many persons with dementia—nearly half of their enrollees—a risk adjustment model that fails to account for dementia will undermine the financial sustainability of PACE programs.

Furthermore, we support providing incentives for Medicare Advantage plans to create innovative care models for beneficiaries with dementia to advance specialty care for this population. Without appropriate risk adjustment, however, plans that serve the sickest beneficiaries may experience a negative disproportionate impact.

The Alzheimer's Association recommends that the 2017 CMS-HCC risk adjustment model for PACE programs and Medicare Advantage plans include dementia codes. Their inclusion will only further CMS's work to improve the predictability of costs, accuracy of payments, and quality of care for vulnerable beneficiaries.

Thank you for the opportunity to comment. The Alzheimer's Association would welcome a chance to serve as a resource to CMS as it considers these important issues and how they relate to individuals living with Alzheimer's and related dementias.

## **5. America's Health Insurance Plans (AHIP)**

America's Health Insurance Plans (AHIP) appreciates this opportunity to provide feedback on CMS' proposed updates to the CMS-HCC Risk Adjustment model for payment year 2017 as described in an October 28th memo to Medicare Advantage Organizations (MAOs), PACE Organizations, Medicare-Medicaid Plans (MMPs), and Demonstrations. The CMS-HCC model is of vital importance to our members participating in the Medicare Advantage (MA) program and in the Capitated Financial Alignment Initiative (FAI) as MMPs and the beneficiaries they serve.

### **GENERAL COMMENTS**

**Importance of improving the accuracy of the CMS-HCC model for dual eligibles.** CMS notes the purpose of the proposed changes is in "response to concerns about the accuracy of the CMS-Hierarchical Condition Category (HCC) risk adjustment model for predicting costs of dual eligible beneficiaries." AHIP strongly supports policy changes to ensure MAOs focusing on beneficiaries with complex needs, including dual eligibles, are fairly reimbursed for their activities to address these needs. We and others have raised concerns the existing payment system in combination with observed barriers to receiving Star Ratings bonuses due to the additional challenges faced by low-income focused plans, likely means the current system does not adequately reimburse for the additional risks taken on by these organizations. Research is demonstrating health plans have put programs in place that are improving the lives of dual eligibles, who can most benefit from the coordinated care, focus on prevention, and delivery of person-centered care these plans provide. Changes that both improve the accuracy of the risk adjustment system while continuing to support the additional activities necessary to address the complex needs of dual eligible beneficiaries are crucial to ensuring MAOs and MMPs focusing on this population can continue to deliver care and improve the lives of the beneficiaries they serve. We commend CMS for the effort the agency has undertaken in this area over the past year.

**Transparency.** We appreciate CMS' attention to these issues and willingness to provide an early signal of its intended approach prior to the Advance Notice of Methodological Changes for 2017. However, we

urge CMS to also provide plans with preliminary coefficients associated with the model segments for the demographic and disease categories.

Early release of these coefficients is crucial to allowing plans to evaluate the impacts of the six new model segments and ensure the proposed approach is achieving its intended goal. As noted in the memo, CMS' evaluations are based on FFS data. To the extent the beneficiary profile is different in MA and FFS – including the prevalence of conditions in the model among the segmented populations – then it is not clear to what extent the reported predictive ratios are indicative of improvements in the accuracy of the model in predicting the costs of the vulnerable beneficiaries served by MAOs focusing on dual eligibles. If CMS does not release these coefficients until the Advance Notice and Draft Call Letter, our members will have only two weeks to analyze the six new segments as well as the other methodological and policy provisions in the Advance Notice and Draft Call Letter. We acknowledge CMS has indicated the final coefficients are still under development. However, preliminary coefficients that CMS used in its own analysis of the impact of the proposal would still be extremely useful for plans.

We also urge CMS to provide more information about alternative approaches that were considered and rejected, including their predictive accuracy. As discussed further below, the proposal introduces a significant new level of complexity and unpredictability in the calculation of risk scores that can adversely affect the bidding process and the ability of plans to review the accuracy of their payments. It is critical that stakeholders be able to assess this proposal not just in comparison to the existing model, but also in comparison with other approaches that may increase accuracy without the same level of complexity.

Additional information on the agency's thinking about impacts of the proposed approach on the new enrollee factors and potential changes to the disease interaction terms – both areas the memo states the agency is considering – would be useful in the plans' evaluation of these changes. As we have noted several times in the past, improved transparency between the agency and plans is fundamental to the future success of the MA program. Our members have unique insights and analytical abilities to assist CMS in developing policies consistent with the agency's goals. We therefore strongly recommend that moving forward, CMS enhance ongoing lines of communication with MAOs and MMPs that permit the exchange of information to promote the development of program policies that best serve the aims of the agency and the beneficiaries served by our member plans. In that vein, we suggest the establishment of a CMS-industry workgroup to consider the potential impacts of the proposed changes and consider if modifications are needed to improve the approach.

**Impact of the proposed approach on the MA program.** The agency also has not provided analysis on the impact of CMS' proposals on funding to the program as a whole. This fact is a fundamental consideration in plans' evaluation of the proposed changes, especially in the absence of preliminary coefficients associated with the new model segments. As noted above, we and our members are strongly committed to changes in the risk adjustment model that improve its accuracy, especially for beneficiaries with complex needs. However, changes that reduce the overall funding for the program are inconsistent with the goals of promoting stability for beneficiaries enrolled in MA plans, especially when the Affordable Care Act's funding cuts will continue to be phased in for 2017 for one-third of the country, uncertainties associated with ICD-10 and the use of diagnoses obtained from encounter data (without a finalized filtering logic) are likely to affect plan payments, and many plans are experiencing lower payments due to the full implementation of the 2014 risk adjustment model.

**Impact on the bidding process.** The difficulty in predicting the accuracy and the impact of the proposed approach on the MA program is a byproduct of its complexity. CMS proposes to separate the current



community model into six segments reflecting full benefit (FB) dual aged, FB dual disabled, partial benefit (PB) dual aged, PB dual disabled, non-dual aged, and non-dual disabled populations. MA plans are unlikely to have prior experience with a six-segment model. Without early release of the preliminary coefficients requested above, MAOs will have a very short time to understand how the new model may affect their revenue needs as part of the bidding process. Moreover, the concurrent determination of Medicaid eligibility further complicates plans' activities to bid effectively and determine the accuracy of CMS payments before they are finalized. These issues are further complicated by other uncertainties plans are facing prior to affecting 2017 bidding, including assessing the impact of the transition to ICD-10 on plan revenues and the use of encounter data to determine plan risk scores, and other ongoing issues of concern. There may be other effects of the proposed approach to risk adjustment on the bidding process, and it will be important that CMS and plans have sufficient information necessary to proactively address these issues before the Advance Notice and Call Letter are released.

While we offer comments to the memo below, our feedback is unfortunately limited by the absence during this comment opportunity of the detailed information requested above. We strongly urge the agency to release preliminary coefficients, impact analyses, information about other proposals considered, and the other information detailed above prior to the issuance of the Advance Notice and Draft Call Letter, to allow plans to provide a more informed and meaningful response to the proposed approach.

#### **SPECIFIC COMMENTS**

**Concurrent Accounting of Dual and Disability Status.** The memo notes dual status would be determined concurrently "based on the payment year status". It is therefore our understanding dual status could change from month-to-month under this approach.

While we support the agency's focus on ensuring payment accuracy through the use of concurrent data, there may be a number of complicating factors that work against this goal. Unlike for example community/institutional status, low-income beneficiaries' Medicaid eligibility status often changes several times during a payment year. In the past, MA plans have had difficulty receiving accurate Medicaid eligibility information from states. Moreover, eligibility is commonly established on a retroactive basis, meaning accurate payments for beneficiaries will be more difficult to track for the agency and our member plans and add complexity to the bidding process as noted above. In fact, we understand CMS has contracted with an outside entity to track retroactive changes in eligibility. Of note, the contractor's current Standard Operating Procedures (SOPs) state an MAO's need to update Medicaid status "should be minimal," and an MAO is not required to report eligibility on a monthly basis or a mid-year termination of Medicaid status, because only one month of Medicaid status is needed to affect the risk score. The SOPs also indicate that occasionally MAOs "may experience a discrepancy with the risk adjustment payment that is attributed to an incorrect Medicaid status posted for a beneficiary in CMS' Medicare Advantage Prescription Drug (MARx) system," and must update the beneficiary's Medicaid status to correct the discrepancy. The proposal therefore has the potential to significantly change MAO and CMS operations.

These changes, in combination with the additional uncertainties in the MA payment environment described above, could significantly alter our members' ability to project revenue requirements during the bidding process. For these reasons, we believe additional time is necessary to better understand the practical implications of implementing a concurrent approach to Medicaid eligibility, including the impact on payment accuracy given the complexities involved.

**Determination of Disability Status.** On page 4 of the October 28th memo, CMS states “aged and disabled are mutually exclusive – a beneficiary is either aged or disabled for a year based on age as of February 1.” Table 4 is unclear about the accuracy of the current model or the proposed model for beneficiaries with disabilities over age 65. It is therefore difficult to ascertain whether treating these individuals under the aged or disabled segments is appropriate. We request the release of additional information from the agency to allow this analysis to take place.

**Consideration of Alternatives.** Page 6 of the memo notes the agency also considered an alternative in which the model had three community segments – FB dual, PB dual, and non-dual – but rejected it because of the superiority of the 6-segment model in predicting costs at the decile level and HCC level. However, the agency does not provide additional information to allow a comparison between these two alternatives. While we would expect further segmentation of the model to result in predictive ratios closer to one, it is not clear from the information CMS has provided to date whether the differences would significantly affect payment accuracy for FB and PB duals and throughout the program.

We would also be interested in whether CMS evaluated other potential alternatives, such as:

A three-segment model that maintains the existing coefficients for non-duals while redistributing costs between FB and PB duals. This approach seems appropriate given the agency’s finding that “the 2014 model predicts fairly accurately for non-dual eligible beneficiaries”.

Refiguring the Medicaid factors within the existing model to account for the differences between FB and PB duals.

Adding segments to the proposed approach for individuals with disabilities who are aged to provide greater accuracy for this population.

We request the agency provide additional information on these and other alternatives the agency may have evaluated, including preliminary coefficients and estimates of the impact of these options on the MA program. As noted above, without this information it will be extremely difficult for our member health plans to assist the agency in determining whether the proposed alternatives produce the improved accuracy that MA plans and CMS desires while continuing to promote a stable payment environment for the nearly 17 million beneficiaries served by the program.

**Application of the Model to MMPs.** The memo notes the agency “will be releasing separate guidance to Medicare-Medicaid Plans on the implications of these findings for the Medicare-Medicaid capitated financial alignment model demonstrations.” In a subsequent memo sent to MMPs on November 12th, CMS announced that for contract year (CY) 2016, the agency will make adjustments to the Medicare A/B component of MMP rates “to better align MMP payments with FFS costs for full benefit dual eligible beneficiaries.” However, payments will continue to be based on the same CMS-HCC risk adjustment model used for MA plans. The memo also states the final adjustments will reflect any new information the agency collects in response to the comment opportunity on proposed changes to the CMS-HCC risk adjustment model, that adjustments will be determined on a “demonstration-specific basis,” and that “CMS will provide additional information through updated CY 2016 rate letters.” CMS expects to release separate guidance on CY 2017 MMP payments following the release of the CY 2017 MA and Part D Rate Announcement and Call Letter.

We commend CMS for taking this step for 2016 and note it will be critical for the agency to provide the specific operational and technical details on the adjustments to MMPs as quickly as possible. More broadly, we also strongly support CMS applying solutions to improve the accuracy of the risk adjustment model to MMPs. These organizations are on the front lines of testing the value of integrating Medicare

and Medicaid benefits in health plan systems that coordinate care. It is therefore crucial that payment to these organizations be commensurate to the risks they face to ensure the success of these programs and the continued reliance on health plans to provide improved care to beneficiaries with complex needs.

## **6. AmeriHealth Caritas**

With more than 30 years of experience, AmeriHealth Caritas is one of the nation's leaders in health care solutions for those most in need. Operating in 16 states and the District of Columbia, we serve more than 6.9 million Medicaid, Medicare and CHIP members through our integrated managed care products, pharmaceutical benefit management and specialty pharmacy services, behavioral health services and other administrative services.

Given our role in the health care community, especially in providing care to dual eligible individuals, we appreciate that the Centers for Medicare and Medicaid Services (CMS) is allowing us the opportunity to comment on the Proposed Update to the CMS-HCC Risk Adjustment Model for Payment Year 2017.

At this time, AmeriHealth Caritas provides services to more than 8,000 Medicare recipients through our Dual Eligible Special Needs Plans (D-SNPs) and the Medicare-Medicaid Plans (MMP). Adequate funding and sustainability of these programs is not only of paramount concern for our company but also vital to providing critical services to our members. Inadequate funding may cause D-SNPs and MMPs to withdraw from the Medicare program, which could negatively impact members by disrupting services, reducing access and impacting continuity of care efforts for those we serve. We believe the measures outlined in this proposal will go far in addressing these concerns, especially with regard to improved payment modeling, coordination of care efforts and payment methodology for the institutional segment.

Under this plan, CMS is seeking to adjust the under-predictability of the full-benefit dual eligible population that often results in under payment for with the care and services we provide to this population. Improved payment modeling will strongly enhance the sustainability of the D-SNP and MMP programs, thus supporting the coordination and integration of care for the dually eligible population that they serve in the community.

CMS also seeks to better coordinate care for this population. Given the complexity of the health conditions found within the dually eligible population, we support the development of the six segment system outlined in CMS's proposal. An increased ability to manage trend and control utilization will support the realization of the cost savings that these programs promote. We would like to note however, that there is still a need to develop better guidelines around the disabled dually eligible population, especially those with mental health conditions such as depression and anxiety as well as the population that are institutionalized in a facility. We look forward to working with CMS on this in the future.

Additionally, as a company that serves a large segment of the Medicaid population in the United States, we support CMS' efforts to review Medicaid payment factors in the institutional segment to determine if concurrent payment will improve predictive modeling. CMS is again looking at the complexities of this population; this attention can only further improve the care and services for the vulnerable individuals whom we serve.

Therefore, AmeriHealth Caritas supports the implementation of the proposed changes to the risk adjustment model for Medicare Advantage plans, including D-SNPs, in 2017, but does so with the understanding that there is still more work to do. We are also supportive of the MMP contract

guidelines for 2016, as outlined in the November 12, 2015 document from CMS. Our team at AmeriHealth Caritas hopes to continue the dialogue begun today on these issues as we all work to improve methods for coordinating care for the most vulnerable in our communities.

## 7. Anthem

Topic: Part D RxHCC model

We have noticed an issue in the predictive power of the RxHCC for the partial subsidy low income members, similar to what was found in the CMS HCC model. We see that the risk scores for this population overestimate the cost of the population.

**We recommend that a model update accounting for the difference in the full/partial subsidy individuals be made for the RxHCC model as well.**

## 8. Anthem, Inc.

Anthem, Inc. (“Anthem”) appreciates this opportunity to provide comments in response to the Centers for Medicare & Medicaid Services’ (CMS’) HPMS memo, “Proposed Changes to the CMS-Hierarchical Condition Category (HCC) Risk Adjustment Model for Payment Year 2017.” As a committed participant in the Medicare Advantage (MA) program, Anthem looks forward to working with CMS to ensure robust and stable beneficiary-focused care under the program.

Anthem is working to transform health care with trusted and caring solutions. Our health plan companies deliver quality products and services that give their members access to the care they need. With over 72 million people served by its affiliated companies, including more than 38 million enrolled in its family of health plans, Anthem is one of the nation’s leading health benefits companies..

### Overview

A core purpose of the MA risk adjustment model is to accurately predict health care costs and to properly fund MA plans for the care provided. To best support clinically-appropriate beneficiary care, it is vital that the risk adjustment model is an accurate predictor of cost. However, as CMS notes in its memo, the current model over-predicts the cost of partial benefit dual eligible beneficiaries, and under-predicts the cost of full benefit dual eligible beneficiaries. While Anthem appreciates CMS’ efforts to make the model more accurate and predictive of costs, we have also identified several components of the proposal where we recommend changes and/or additional clarification from CMS:

**Additional Transparency Required:** Though Anthem appreciates CMS’ efforts to address flaws in the risk adjustment model, we continue to be concerned with the lack of transparency surrounding risk model adjustments. It is inappropriate for CMS to release a proposal of this magnitude via an HPMS memo, rather than through formal Notice and Comment Rulemaking, as well as without sufficient detail. The memo did not include crucial information, such as the relative factors of the revised model and an impact assessment, which is required for plans to help CMS fully understand the proposal’s impact to consumers and the industry. We urge CMS to release additional information and to respond to plan inquiries as soon as possible. We also request that CMS give plans and other stakeholder’s ample time to assess the proposal’s true impact, following the release of the requested additional information.

**Delay Implementation with a Phase-in Approach:** While we recognize that CMS is committed to addressing stakeholder concerns that the model disproportionately affects dual eligibles, given the magnitude of the proposed changes and the lack of transparency on the impact of these changes,

Anthem suggests that the Agency delay implementation until at least the 2018 plan year, and to phase implementation in over several years.

**Correct Risk Adjustment Model Deficiencies by Implementing a Clinically-Revised Model:** Anthem strongly believes that the MA risk adjustment model requires transparent updates that ensure accurate payments and remove incentives to avoid treating the sickest patients. We thank CMS for continuing to review the risk adjustment model and for contemplating improvements. We urge the Agency to use the release of this proposal as a means to improving the accuracy of the model as a whole and not just for certain patient populations. CMS should undertake a more robust stakeholder-inclusive process to develop a clinically-revised risk adjustment model, ensuring it more accurately reflects the costs of caring for all beneficiaries.

Anthem's detailed comments and recommendations follow below.

### **Additional Transparency Required**

#### ***Changes to the Risk Adjustment Methodology Should Proceed Through a Formal Rulemaking Process***

Anthem has advocated for risk model updates that are fully transparent and subject to a formal public comment opportunity outside of the Advance Notice process. Increased transparency of data, additional insight into model changes, and a longer stakeholder process to review those changes are essential for a sustainable and stable MA program. As such, we thank CMS for beginning to take this feedback into account and for releasing this proposal prior to the release of the 2017 Advance Notice. However, it is inappropriate for the Agency to issue a proposal of this magnitude via an HPMS memo rather than through formal notice and comment rulemaking, as well as without sufficient detail necessary to fully understand and analyze the contemplated updates. Changes to the MA risk model should occur through a transparent regulatory process—with all necessary detail provided—and with a 60-day public comment period. This will ensure that stakeholders have the opportunity to review and assess changes which may have a meaningful impact on beneficiary access and care.

#### ***Release the Relative Factors, an Industry Impact Assessment, and Other Information***

Anthem appreciates CMS' efforts to assess how well the risk model performs for certain beneficiaries, as the purpose of the risk model is to improve the accuracy in predicting health care costs and to properly fund MA plans for those expenses. While the risk model should be clinically appropriate to support beneficiary care, the current iteration of the model consistently under-predicts the risk scores for high-cost populations, which results in underfunding of vulnerable subgroups. While we understand CMS is attempting to address this disparity, we are deeply concerned by the lack of detail included in the proposal, which impedes our ability to help you understand the true impact of the contemplated model changes on plans and, more importantly, on beneficiaries.

Specifically, Anthem asks CMS to release the relative factors of the revised model as soon as possible, and before the issuance of the 2017 Advance Notice in February. Plans also need to quickly know if and how the risk model's disease interaction terms will change in the revised model—Anthem recommends that these terms remain the same as in the current model. In addition, we request that the Agency clarify whether changes will be made to HCCs within the revised model. There was some confusion generated on CMS' November 11th industry call as to how and where normalization will occur—it is imperative that plans know exactly how the adjustment process will occur in order for us provide meaningful comments on these proposed changes. Finally, Anthem asks that CMS publish an industry impact assessment, which would have been made available had CMS released this proposal through the regulatory process.

***Expand Dialogue with Plans and Stakeholders***

In order to fully assess the implications of this and other risk adjustment methodology proposals, it is vital to understand all payment and policy changes CMS is considering for the 2017 plan year. Individual risk adjustment model changes cannot be considered in a vacuum, but must be analyzed along with all other contemplated changes to plan payments to properly understand the complete impact for plans and beneficiaries.

Anthem respectfully reminds CMS that this proposal, if implemented, will not apply in isolation, but will apply in the context of other payment and policy pressures that have required plans to shoulder a trend of negative adjustments due to both mandatory and discretionary changes implemented by CMS. We question whether 2017 is the best time to implement these risk adjustment changes. Plans are already operating in an environment that has brought significant changes to the risk adjustment model every year for the last three years. Furthermore, we are in the process of adapting to a myriad of other risk model-related changes, including the transition to ICD-10 and the ongoing phase-in of encounter data for risk adjustment factor (RAF) scores. The Agency's risk model proposal adds an extra layer of complexity to an already challenging environment. To that end, Anthem is very concerned about the cumulative impact that the policy changes proposed for 2017 will have on the stability of the MA program, directly impacting beneficiaries.

Without better insight into the 2017 environment, we cannot fully analyze this proposal, which will undoubtedly have a direct and significant impact on beneficiary care and program stability. In order to sufficiently assess how the proposed changes will affect the MA program, Anthem requests increased transparency into CMS' processes for updating the risk adjustment model and contemplating other payment changes. As detailed previously in this letter, we recommend that all proposals be included in a formal notice and comment rulemaking – with at least a 60-day public comment period. In addition, Anthem recommends that CMS meet with plans regularly to discuss potential risk adjustment updates. The meetings should foster accountability and open a transparent dialogue between CMS and plans, with CMS detailing its work on risk adjustment, including proposals which may later be released.

***Provide Clarification on the Goals of the Proposal***

CMS indicates that the risk model changes it is contemplating aim to address concerns by stakeholders that the model may disproportionately affect specific populations, particularly dual eligible beneficiaries. The findings put forth by CMS (i.e., that socioeconomic status (SES) has a material impact on costs and on use of care) underscore plans' requests for an adjustment to account for SES in the MA Star Ratings system, as well. In fact, this is an area where plans have felt an even greater impact.

The Star Ratings do not take into account demographic differences such as low-income seniors who often experience higher rates of chronic disease, disability, and mental illness, which often results in increased resources and slower health improvement. Those with low-SES characteristics are more likely to become sick, get diagnosed and treated later, and die sooner than individuals with higher-SES. These beneficiaries are consistently more complex to manage than higher-SES beneficiaries, even after adjusting for socioeconomic characteristics.

Low-SES beneficiaries are more likely to have certain risk factors (e.g. low-income, low levels of education) that are strongly correlated with poorer health outcomes. When low-SES populations are covered by a health plan, their poorer health outcomes significantly influence health plan performance on quality metrics. The composition of a beneficiary population has a significant influence on performance ratings. The current 5-Star rating system penalizes plans that care for a greater proportion

of low-SES beneficiaries by not adjusting for the significant affect that low-SES has on population health outcomes and therefore plan performance. Therefore, Anthem urges CMS to not only address the impact of low-SES within the risk adjustment model, but to move forward with revisions to the Star Ratings that properly account for the impact of low-SES, too. To that end, Anthem is in the process of reviewing CMS' recent proposals for possible analytical adjustments to the Stars and looks forward to continuing to work with the Agency on this issue.

***Specific Questions Requiring Additional Transparency***

As stated above, in order for Anthem to assess the true impact of this proposal on our members, our business, and the industry as a whole, we request that CMS quickly provide answers to the following questions:

What are the relative factors CMS is using in the revised model?

How did CMS calculate the predictive ratios included in the proposal, and how do these?

Can the Agency describe the development of any calculated factors in what it may propose as the actual model?

How does CMS define a predictive ratio of 1.0 in the six new community segments? Are new enrollees and/or institutional enrollees included in the calculation of the predictive ratios?

Why are the proposed revisions solely focused on dual status, rather than the underfunding of vulnerable, chronically-ill beneficiaries more broadly?

What is the impact of the revised model on disease coefficients?

Can CMS elaborate on whether the sample size of each of the six segments is appropriately large enough to build an accurate, reliable model?

What are the results of CMS' industry impact assessment?

Will the disabled-disease interaction terms in the current model be present in all of the six new model segments (given that some aged will also be disabled)?

Will the revised model appropriately account for beneficiaries who are receiving significant levels of care but who are not institutionalized?

Does implementation of the new model have broader implications for the calculation of MA county benchmarks?

Does CMS contemplate implementing a look-back period where CMS may update incorrect duals status and make retroactive financial changes?

CMS' memo states that the Agency is exploring whether the disease interaction terms should differ by model. As stated previously, Anthem recommends that the revised model treat these terms in the same way the current model treats them. In addition, Anthem notes that the definition of a dual eligible under CMS' proposal (based on the payment year status) is not consistent with the definition used in the current environment (based on the base year status). While Anthem is supportive of the inclusion of concurrent payments for certain factors in the risk model, we do not believe that concurrent payments for dual status are appropriate. As CMS states in its memo, concurrent dual status could result in beneficiaries having months in one or more of the six proposed subpopulation statuses in the payment year. We believe that this would not only result in operational and administrative burdens for both CMS

and plans, but that beneficiaries would be negatively impacted by the “churn” between partial-benefit and dual-benefit dual status throughout the year.

### **Technical Recommendations**

Should CMS move forward in implementing this proposal, Anthem urges the Agency to delay implementation until at least the 2018 plan year, and to phase implementation in over several years. As mentioned earlier, plans are already operating in an unstable environment that has brought significant changes to the risk adjustment model every year for the last three years. We are also adapting to additional changes such as the transition to ICD-10 and the phased incorporation of encounter data into risk score computation. Delaying implementation of this proposal until 2018, as well as phasing-in the new proposal, would ensure that plans have:

Appropriate time to review the proposal;

The ability to engage in true dialogue with CMS on the proposal; and

An opportunity to make necessary adjustments to IT systems, provider contracts, etc.

Anthem asks CMS to consider the operational challenges that plans will face as this proposal is further considered and potentially implemented. From a business perspective, plans prepare for new initiatives 3 to 5 years in advance. CMS’ near constant changing of the risk adjustment model hampers our ability to not only operate under regular business processes, but to provide the stable, beneficiary-focused care our members so highly value. Rather looking forward and innovating for the benefit of MA enrollees, plans are forced to look back and adapt to large-scale changes. In sum, Anthem urges CMS to slow its pace, engage more directly with plans, and to roll out the changes contemplated under this proposal later and in phases.

Finally, should CMS move forward in implementing this proposal, we also encourage the Agency to similarly revise the CMS-Prescription Drug Hierarchical Condition Categories (CMS-RxHCC) risk adjustment model for payment year 2018 or beyond to better account for dual eligibles. Anthem notes that the patterns CMS between full-benefit and partial-benefit duals in the MA program are also experienced in Part D; it is important that the two programs treat enrollees in a consistent manner.

### **Correct Risk Adjustment Model Deficiencies by Implementing a Clinically-Revised Model**

Anthem strongly believes that the MA risk adjustment model requires transparent updates that ensure accurate payments and remove incentives to avoid treating the sickest patients. We thank CMS for continuing to review the risk adjustment model and contemplating improvements.

Data shows that the current model underfunds care provided to vulnerable and chronically-ill beneficiaries, who may or not be dual eligible. We are concerned that CMS’ proposal will adversely impact the accuracy of payments for beneficiaries who are not dual eligible—and that the impact will be felt even more acutely among those non-dual beneficiaries who are suffering from complex medical conditions. Rather than exacerbate the flaws in the current model—as this proposal would—Anthem encourages CMS to improve the accuracy of the model as a whole and not just for certain patient populations. We believe that model improvements should look beyond any one individual condition—and even beyond just the predictive accuracy of the model—and to more groupings of conditions, beneficiaries with multiple comorbidities, and improved payments for costs incurred during the final year of life.

We urge CMS to undertake a more robust stakeholder-inclusive process to develop a clinically-revised risk adjustment model, ensuring it more accurately reflects the costs of caring for all beneficiaries. We



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Risk Adjustment Model for Payment Year 2017**

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believe more can be done to bring us to a properly functioning, clinically-appropriate risk model that ensures that health plans have the same incentive to enroll and care for all beneficiaries regardless of their health status, therefore supporting patient care. We also recommend that CMS more fully engage clinical professionals in the review of the risk model and implementation of any further changes to ensure the model fully supports the provision of clinically-appropriate care.

Additionally, due to its prospective nature, the model fails to appropriately compensate plans for specific care provided. While we do not believe that a concurrent adjustment for dual status is appropriate, Anthem does support including a concurrent adjustment to pay plans for costs incurred to ensure all care provided is appropriately represented in certain circumstances. There is precedent for using a concurrent system in other risk adjustment models, such as the one used for the exchanges and now, in the MA program, with CMS' proposal to have dual status in the community segments be concurrent. Anthem encourages the Agency to explore a similar option for other, more appropriate factors in the model.

**Medicare A/B Payment to Medicare-Medicaid Plans Participating in the Financial Alignment Initiative for Contract Year 2016**

Anthem appreciates CMS' recent efforts to improve payment rate accuracy for Medicare-Medicaid Plans (MMPs) participating in the capitated financial alignment model during contract year (CY) 2016. We believe that payment accuracy is critically important for the provision of care, and commend the Agency for aligning MMP payments with FFS costs for full-benefit dual eligible.

As CMS finalizes adjustments to the 2016 Medicare A/B FFS rate component, we ask the Agency to provide additional clarity around its approach. Further insight into CMS' process will enable Anthem and others in the plan community to provide meaningful feedback that aims to reduce administrative and technical burdens and—more to the point—ensure that beneficiaries are receiving the best care possible.

Anthem's questions regarding the adjusted Medicare A/B payment to MMPs are as follows:

Can CMS provide the actual new set of HCC models so that plans may apply them directly to their MMP populations and assess impacts?

Will there be any changes to how the new HCC models will be applied to A/B rates versus what is done today?

Will current schedules and approaches for reducing coding intensity remain?

Will there be any other changes to normalization or other aspects of risk score application to the benchmarks?

Can CMS provide a formal, written representation of exactly how the new model will be applied to develop payments?

Can CMS expand on what is meant by adjusting for the proportion of revenue in each of the sub-populations? Clarification around the following two sentences is requested: "Specifically, the adjustment will consider the demonstration-specific proportion of revenue associated with each subgroup in the target population. For example, we will take into account the share of revenue for individuals over and under age 65, and for community versus institutional enrollees."

Does CMS have estimates for how the final adjustment will vary across demonstration populations?

Given that CMS anticipates some retroactive adjustments may occur in the early month of CY 2016, how does the Agency envision operationalizing those adjustments? Does CMS have a sense of when retroactivity would cease?

Will there be any operational changes or adaptations that CMS expects plans will have to make in order to accept these payment adjustments?

We look forward to receiving responses to these questions, along with any other pertinent information, when CMS releases updated CY 2016 rate letters.

Anthem appreciates this opportunity to provide input on CMS' Proposed Changes to the CMS-HCC Risk Adjustment Model for 2017. We are eager to work with CMS to ensure the delivery of stable, robust benefits and quality care via the MA programs.

## **9. Appalachian Agency for Senior Citizens**

This constitutes the response of Appalachian Agency for Senior Citizens, d.b.a. AllCARE for Seniors to CMS' request for comment on the proposed changes to the HCC risk adjustment methodology.

### **Background**

AllCARE for Seniors is a Program of All-Inclusive Care for the Elderly that has operated in Cedar Bluff, Virginia for 7 1/2 years. We serve 86 individuals with significant complex chronic conditions and functional or cognitive impairment. All of our participants meet the state's definition of requiring a nursing home level-of-care. Approximately 38.7 % of our enrollees have dementia.

We appreciate CMS' consideration of the following comments and recommendations:

### **Comments**

- 1) AllCARE for Seniors believes that developing risk factors for six distinct subpopulations of Medicare beneficiaries to acknowledge the impact of Medicaid eligibility status, along with institutional vs. community residence, will improve the accuracy of the risk adjustment system. AllCARE for Seniors supports the use of the subpopulations' distinct risk factors for establishing payments to PACE organizations. AllCARE for Seniors notes that approximately 96.1% of our enrollees are fully dual-eligible for Medicare and Medicaid.
- 2) In addition to calculating risk factors for the six distinct subpopulations of Medicare beneficiaries, CMS requests comments on changing the current PACE HCC model (HCC v. 21) to the 2014 model being phased in for MA plans (the "2014 model"). AllCARE for Seniors, as we have stated previously in response to CMS' 2013 advance notice of payment when it initially proposed the 2014 model, strongly recommends retaining the current PACE HCC model (HCC v.21) for PACE organizations. Shifting PACE to the 2014 model will reduce the performance of the risk adjustment model for PACE enrollees relative to the model that is currently in place.

The Evaluation of the CMS-HCC Risk Adjustment Model completed for CMS by RTI and released in March, 2011 assessed the predictive ratio of the CMS-HCC risk adjustment model v. 21 relative to an earlier version, v.12. The evaluation found that v. 21 accurately predicts costs for Medicare beneficiaries and, in particular, significantly improved model performance over v.12 for beneficiaries with dementia.

Nearly 38.7% of all AllCARE for Seniors enrollees have dementia, as of August, 2015. The HCCs (51 and 52) for beneficiaries with dementia that are included in v. 21 and are related to its improved

predictive value in comparison to v. 12 are not in the 2014 HCC model. Because of the significance of dementia in the PACE enrollee population, we provide detailed comments on this condition and the impact of its removal from the HCC risk adjustment model below.

Further reducing the 2014 HCC model's accuracy when applied to PACE is its lack of HCCs that support the identification of interactions between early stages of kidney disease and congestive heart failure. Approximately 45.3% of AllCARE for Seniors enrollees have a diagnosis of CHF, and of these 12% are diagnosed with an early stage kidney disease (HCC 138, 139, 140 or 141). We have estimated that the 2014 HCC model would reduce the average HCC score for AllCARE for Seniors beneficiaries with congestive heart failure and early stage kidney disease by -20.58%. In combination, the 2014 HCC risk adjustment model results in a significant degradation of the CMS-HCC risk adjustment model's predictive value for the large majority of PACE enrollees.

- 3) The CMS-HCC risk adjustment model for PACE enrollees needs to include dementia. Because of the significance of dementia for the cost and care of AllCARE for Seniors participants, the CMS-HCC risk adjustment model for PACE needs to include HCCs for dementia diagnoses. As noted earlier, approximately 38.7% of AllCARE for Seniors participants are diagnosed with dementia, as indicated by the percent triggering either HCC51 or HCC52 for dementia in the CMS-HCC risk adjustment model currently applied to PACE (v.21). Removal of dementia related HCCs from the risk adjustment model significantly reduces the predictive ratio of the model for these PACE enrollees and, as a result, will undermine the financial sustainability of PACE programs.

Risk adjustment without HCCs for dementia results in substantial under prediction of the costs of care for enrollees with dementia, who comprise a large proportion of PACE organizations' total enrollment.

Referring to the Evaluation of the CMS-HCC Risk Adjustment Model that CMS released in March 2011, RTI compared predictive ratios for HCC chronic disease groups and concluded that v.21 of the CMS-HCC model was far superior to v.12 in predicting costs for beneficiaries with dementia. For beneficiaries with dementia, v.21 (with HCCs for dementia) of the model achieved a predictive ratio of 1.000 compared to 0.858 for v.12, which like the 2014 model used for MA plans lacks HCCs for dementia. This indicates that predicted costs for beneficiaries with dementia under v.12 are essentially 14% lower than actual costs. Based on historical diagnostic data, NPA's comparison of PACE organizations' mean HCC scores for PACE enrollees with dementia in the v21 model vs. the 2014 model used for MA plans indicates that the 2014 model generates mean HCC scores that are, on average, 21% lower than v.21. We are deeply concerned that exclusion of dementia HCCs in the 2014 model leads to substantial underpayment for PACE enrollees with dementia. These individuals account for almost half of all PACE enrollees.

Failure to recognize dementia related costs is not consistent with CMS efforts to serve more people needing long-term services and supports through health plan options.

As CMS and states seek to enroll more people needing long-term services and supports in managed care options, the impact of under predicting costs associated with dementia will be broader than PACE. While for most Medicare Advantage plans the current prevalence of dementia is low, resulting in a minimal financial loss associated with the removal of dementia as a risk factor, the impact on PACE and other emerging options for people who need long-term services and supports, a large proportion of whom will have dementia, will be much greater.

4) Retaining the current PACE HCC model (v. 21) will reflect the costs of preventing early stage pressure ulcers. A shift to the 2014 model would eliminate HCCs for pressure ulcers categorized as stage 1 or 2. Without these HCCs, the risk adjustment model would not take into consideration the care planning and treatment required in order to prevent these ulcers from escalating to a stage 3 or 4 ulcer. In the frail population served by PACE, individuals' compromised skin condition along with coexisting medical conditions such as diabetes and peripheral vascular disease often lead to the development of pressure ulcers. The early interventions PACE organizations avoids lower stage ulcers from progressing to stage 3 or 4 ulcers. If not prevented, these higher stage ulcers can require high cost procedures, hospitalizations and in some cases may lead to death. The HCC model for PACE should recognize and incentivize, the investment in prevention made in caring for people with stage 1 and 2 ulcers.

### **Recommendations**

1. Retain the current v.21 of the CMS-HCC risk adjustment model for PACE. NPA strongly recommends that CMS retain the current v. 21 CMS-HCC risk adjustment model used for PACE payment. This HCC model recognizes the importance of dementia in predicting Medicare costs. In addition, this model appropriately reflects the costs of care for PACE participants with early stage pressure ulcers and early stage kidney disease that is comorbid with congestive heart failure. The combination of PACE county payment rates, the current v. 21

CMS-HCC risk adjustment model and frailty adjustment generates appropriate payment for our high cost population of Medicare beneficiaries.

This assessment is based in part on an analysis, previously shared with CMS by the National PACE Association, undertaken in response to CMS' implementation of the frailty adjustment model applied to PACE beginning in 2008. The study identified a PACE-like population from among respondents to the National Long Term Care Survey (NLTCS) and compares their observed costs in FFS to the costs predicted by the v. 12 CMS-HCC risk adjustment model and revised frailty adjustment model. The study concluded their payments were substantially under predicted. A significant proportion of this under prediction was addressed by implementation of the v. 21 model in CY2012 and further addressed by implementation of the recalibrated frailty adjustment model in CY2013. Applying the MA 2014 model to PACE will undo the improvements in the risk adjustment methodology for PACE that have been achieved to date.

2. Apply distinct risk factors for the subpopulations of Medicare beneficiaries described in the request for comment to the calculation of payments for PACE organizations. We concur with CMS that dual-eligible status is a strong determinant of costs to the Medicare program. Establishing distinct risk factors for populations based on this eligibility status, along methodology for PACE. It with institutional vs. community residence status, will improve the accuracy of the payment.

In addition to the improved performance relative to the MA 2014 CMS-HCC risk adjustment model, retaining the v. 21 model offers the benefit of payment stability for PACE organizations. As comparatively small, not for profit organizations, PACE programs are particularly compromised in their ability to make financial commitments regarding developing and operating PACE by stark annual changes in Medicare's payment methodology.

## **10. ArchCare**

We would like to thank CMS for this new proposed model. Revising the risk model shows to be more reflective of our population risk and services provided and does more accurately show favorable after

completing a rough estimate of the impact to all our plans. **We are supportive of the proposed changes.** In the e-mail attachment on October 28th and also on the November 10th CMS call regarding these proposed changes, CMS had stated they did not include PACE or ESRD model as part of this new model. **We ask that CMS consider implementing these changes to the PACE program as well.**

## **11. Arizona Association of Health Plans (AzAHP)**

On behalf of the Arizona Association of Health Plans (“AzAHP”), representing the companies who contract with the Arizona Health Care Cost Containment System (“AHCCCS”) to provide for the health care needs of Arizona’s most vulnerable citizens, we write to comment on the proposed changes to the CMS-HCC risk adjustment model for payment year 2017. We very much appreciate the opportunity to provide you with this feedback.

The 14 member health plans that make up the AzAHP contract with AHCCCS to meet all the health care needs of our members, including acute care and behavioral health, as well as long-term care. We are the private half of the public-private partnership that makes the Arizona AHCCCS model one of the most successful managed care programs in the Nation.

Our plans serve the needs of our members by advancing innovations and collaborating to implement cost savings measures, even as we compete in a highly regulated industry.

We are a diverse group – nonprofit and for-profit, owned by commercial insurers and local hospitals, representing different service areas and members. Our plans have abundant expertise, and all boast ongoing and innovative pilot programs designed to improve the health of our members, not just treat their symptoms.

A specific example of these innovations is how, for almost a decade, each of our Medicaid plans also administers a Medicare D-SNP plan to coordinate care for our Medicaid dual eligible members. This has resulted in a nationally recognized number of 58,000 dual eligible members “aligned,” receiving all Medicare and Medicaid physical and behavioral health services through one organization. We believe this alignment leads to high beneficiary satisfaction and quality of life for those we serve. This D-SNP model must be financially viable for Arizona to continue and other states to implement coordination under the D-SNP model.

We applaud CMS’s efforts to correct the underpayment of Medicare Advantage plans that serve the aged and disabled populations, and we are hopeful this adjustment will allow for even greater innovation and excellence that has already yielded better health outcomes for Medicare Advantage SNP beneficiaries in Arizona and beyond.

We agree with many of the specific comments that our national partners, sister organizations, and AHCCCS have voiced regarding the proposed changes. Broadly, we believe the net effect of these changes is necessary to financially align the costs of caring for the most vulnerable members of our population and ensure that covered services are adequately funded. When the funding is aligned, our members benefit from additional resources and benefits needed to improve their overall health status. Compared to the general Medicare population, dual eligible members have higher social and behavioral health needs. Our plans go above and beyond to serve the needs of our members.

Indeed, dual eligible beneficiaries, although a small proportion of the Medicare and Medicaid populations, account for a disproportionate amount of spending when compared to the traditional Medicare and Medicaid populations. Specifically:

Duals are 20% of the Medicare population, but account for 31% of spending; and

Duals are 15% of the Medicaid population, but account for 39% of spending.

We believe the integration of care offers a promising, viable, and efficient way of ensuring that people most in need of deliberative and coordinated care have the critical access to the services they deserve. Doing so, however, requires appropriate financing which accounts for the complex needs of the full benefit dual population and its aged and disabled subsets.

We are grateful for the opportunity to comment on this critical issue and sincerely appreciate your reaching out to the stakeholders to share their expertise as you consider changes to the current risk adjustment model.

## **12. Arizona Health Care Cost Containment System (AHCCCS)**

The Arizona Health Care Cost Containment System (AHCCCS) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed "HCC Risk Adjustment Model Changes for Calendar Year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies," released on October 28, 2015.

AHCCCS, Arizona's single state Medicaid agency, provides health care coverage to the State's acute and long-term care Medicaid populations, including dual eligible members. Since 1982 when it became the first statewide Medicaid managed care system in the United States, AHCCCS has operated under a federal 1115 Research and Demonstration Waiver that allows for the operation of a total managed care model. Over the past nine years, AHCCCS has pursued strategies to better align service delivery by reducing fragmentation and increasing system alignment and integration. For the 145,000 dual eligible members enrolled in AHCCCS, Arizona has achieved this integration through the Medicare Dual Special Needs Plan model. AHCCCS requires all Medicaid contracted managed care organizations to also be Dual Eligible Special Needs Plans (D-SNPs). The D-SNP requirement offers dual beneficiaries the opportunity to align all Medicaid and Medicare service coordination through one health plan. We commend CMS' interest in advancing policy for dually eligible beneficiaries through the spectrum of Medicare and Medicaid programs, in strengthening the role of D-SNPs to serve as a platform for integration, and advancing the alignment of Medicare and Medicaid functions inside and outside of national demonstration authority.

In our March 6, 2015 response to the Medicare Advantage Capitation Rates and 2016 Call Letter, AHCCCS conveyed our concern that the HCC model does not take into account functional impairment and that it underpays for comorbidities. CMS' October 28, 2015 memo confirms the 2014 model in use today significantly under predicts acuity and therefore costs for full-benefit dual eligible. The model's under prediction is greatest for full-benefit dual eligible enrollees (8.6%), of which compose 100% of enrollees in Arizona's D-SNPs. CMS' proposed framework to correct the risk model would reverse the systematic under payment uncovered for dual eligible beneficiaries in MA and, in particular, the under payment for full-benefit dual eligibles in MA who represent the poorest, sickest, costliest, and most vulnerable subpopulations in our healthcare system.

AHCCCS strongly supports CMS' proposal to restructure the current risk adjustment model to include six separate community segments in order to more accurately reflect these subgroups' distinct disease and cost profiles.

The proposed revisions are a step towards payment equity for plans that exclusively or disproportionately serve dually eligible beneficiaries.

These modifications are appropriate and necessary to align incentives for plans to enroll and provide appropriate, high quality services for this complex population.

Further, CMS's proposal would ensure the sustainability of the marketplace by improving the financial viability of the MA D-SNP program. A core principle of risk adjustment is to ensure that global payments do not create incentives to avoid costly patients with complex needs or to encourage favorable selection of only healthy individuals.

As the health care system moves from an acute to a chronic care approach, MA plans increasingly look to organize care around defined populations that require a unique array of benefits and services. This payment proposal takes an important step toward enabling all MA plans to advance population-based health management methods for aged, dual eligible and disabled beneficiaries.

AHCCCS believes that the benefits of these programs will be undermined if many D-SNPs are unable to maintain financially viable programs because CMS' HCC risk adjustment model fails to adequately address the costs of serving beneficiaries who participate in these programs.

AHCCCS agrees that there is abundant evidence in the risk adjustment literature that the MA risk adjustment methodology under predicts costs for certain high-cost/high-risk beneficiaries and under values the cost of caring for full duals vs non-duals commensurate with costs in traditional Medicare. In 2013, Milliman conducted an actuarial analysis of changes in the 2014 HCC Model and the impact on about 15 specific high-risk/high-need subgroups, including duals vs. non-duals, institutional vs. non-institutional beneficiaries, under-65 adults with various types of disabilities and persons with the various chronic conditions approved for exclusive enrollment in C-SNPs. The analysis compared average FFS expenditures and MA risk-adjusted, county benchmark payments for these groups in 2014 using the Medicare 5% sample. Among the major findings are that 2014 MA risk adjusted benchmark payments for duals are nearly 8% less than for non-duals, compared to payment for duals and non-duals served in traditional Medicare, with comparable demographic factors, and significantly less for some dual subgroups, with benchmark payment rates actually less than fee-for-service (FFS) expenditures for certain high- risk/high-need dual subgroups.

**Regarding timelines, we strongly encourage CMS to implement the new model for D-SNPs plans no later than payment year 2017.**

We encourage CMS to extend the revised model to other plans outside of the financial alignment demonstration program. We believe the revised model will help ensure ongoing and robust participation of Medicare Advantage Special Needs Plans (SNPs) for dual eligible and Fully Integrated Dual Eligible SNPs. We acknowledge there are policy and operational issues that must be considered in order to do so. However, we encourage CMS to update the risk adjustment model for MA D-SNPs no later than 2017.

Further, underfunding health plans that serve full-benefit duals in particular potentially put at risk the financial viability of specialized managed care, not because of a lack of interest in the marketplace but because the existing HCCs do not account for the added costs and care complications associated with specializing in care of high-risk/high need persons. This could have a devastating effect on hundreds of thousands, if not millions, of vulnerable beneficiaries with complex care needs who have freely chosen to enroll in specialized managed care programs. It could create financial hardship for for-profit and not-for-profit companies that have taken it upon themselves to finance specialty care programs.

Specifically, the Milliman study showed that in 2014, MA risk adjusted benchmarks for some Medicare beneficiaries are actually less than payments under Medicare fee-for-service. The nondual subgroups

considered to be disadvantaged the most because they have a benchmark-to-cost ratio lower than the nationwide average full Medicare population benchmark-to-cost ratio are institutional beneficiaries at 86.5% of Medicare FFS and CKD at 96.1% of Medicare FFS. The benchmark-to-cost ratios are even lower for dual eligible subgroups with certain conditions, including:

- Dual eligible with CKD (90.5%)
- All dual eligible with risk scores of 3.0 and above (94.7%)
- Dual eligible adults with physical disabilities (96.3%) and, specifically those with risk scores of 3.0 and above (91.7%)
- Dual eligible with chronic lung failure (96.4%)
- Dual eligible with drug and alcohol disorders (96.2%) and, specifically, those with risk scores of 3.0 and above (92.2%)

Arizona elected not to pursue a duals demonstration because of the ongoing success of the D- SNP model. Through careful, incremental strategies, Arizona has achieved alignment (enrolled in the same plan for both Medicare and Medicaid services) for over 42% of all duals. This represents over 61,000 dual members statewide. The D-SNP model has given Arizona the ability to align incentives that drive health plan performance and support alignment efforts to better coordinate care for dual members and has made AHCCCS a nationwide model of success. We applaud CMS's efforts to encourage all plans to deliver quality care to the vulnerable members they serve, but changes must be made to ensure equity throughout the system. Arizona's continued success depends on the ongoing viability of the D-SNP model. This includes members' ability to access supplemental benefits, such as dental, vision, and hearing that have a direct impact on the health of dual eligible members.

Thank you for the opportunity to provide input. We look forward to continuing to work with you to promote integrated care for the Medicare-Medicaid population towards our shared goals of program efficiency and improved outcomes.

### **13. Blue Cross Blue Shield Association (BCBSA)**

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments in response to the Centers for Medicare & Medicaid Services' (CMS's) HPMS October 28, 2015 memorandum, "Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017" (Risk Adjustment Memorandum).

BCBSA represents the 36 independent Blue Cross and Blue Shield Plans (Plans) that currently provide health care coverage to approximately 105 million Americans. The majority of Plans contract with CMS to sponsor Medicare Advantage (MA) and/or Part D (Part D) Plans in the market today. We are pleased to serve several million Medicare beneficiaries under these two important programs.

BCBSA and Plans support CMS's efforts to improve the accuracy of the CMS-Hierarchical Condition Category (HCC) risk adjustment model in predicting the costs of Medicare beneficiaries for purposes of adjusting payment to MA Organizations and Part D Plan Sponsors (collectively, Plan Sponsors). In particular, we appreciate CMS's focus on improving the CMS-HCC risk adjustment model's ability to predict more accurately the costs of care for individuals dually eligible for Medicare and Medicaid benefits (Dual Eligibles). Such efforts, especially when combined with CMS's ongoing analysis of whether and how to modify the Part C and D Quality Star Ratings to adjust for the impact of enrolling a



disproportionate number of Dual Eligibles, reflect CMS's commitment to paying Plan Sponsors accurately for the risk profile of their members.

BCBSA and Plans also appreciate CMS's dedication to transparency and responsiveness to stakeholder comments as to advancing proposals in advance of the annual Advance Notice and Call Letter. We are committed to providing CMS with meaningful feedback that CMS can use to improve the MA and Part D Programs. Accordingly, we urge CMS, as noted below, to provide stakeholders with additional information related to the proposed CMS-HCC risk adjustment model changes, as well as more time with which to provide comment. Without such additional information and additional time, Plans are hindered in their ability to assess the impact of these proposals and provide comments.

1. CMS Should Propose Changes to the CMS-HCC Risk Adjustment Model Through Formal Notice and Comment Rulemaking.

BCBSA and Plans urge CMS, as we have in the past, to use the federal formal notice and comment rulemaking process to make changes to the MA and Part D risk adjustment methodologies. Changes in risk adjustment methodologies have significant revenue implications and may require substantial operational adjustments. Without adequate time to review and analyze proposals, Plans are challenged to fully assess proposals and to provide CMS with meaningful feedback.

Proposing risk adjustment methodology changes through notice and comment rulemaking would be consistent with CMS's procedures for making other payment-related changes under the Medicare Program. For example, CMS proposed changes to the Medicare Shared Savings Program for Accountable Care Organizations (ACOs) for the 2015 reporting period on July 11, 2014 in the Federal Register. Stakeholders had 60 days from the release of the proposals to submit comments on the proposed changes. CMS similarly provides a 60-day notice period for proposed changes under the Inpatient Prospective Payment System. This time period is in stark contrast to the mere 15 days CMS provides to Plan Sponsors when CMS proposes changes only through the Advance Notice of Methodological Changes for an upcoming contract year and the current 28-day comment period afforded under this Risk Adjustment Memorandum.

We understand that CMS intends, as shared in the recent CMS stakeholder call, to provide more information related to the proposed CMS-HCC risk adjustment model changes in the Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for the Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Advance Notice) to be released in February 2016. Although BCBSA and Plans appreciate this effort to provide transparency, we submit that the 15 day comment period afforded by the Advance Notice does not provide stakeholders with adequate time to review and meaningfully comment on such significant proposals. The advance release of the Risk Adjustment Memorandum – indicating that changes are coming but providing an incomplete proposal lacking supporting data – does not remedy the challenges associated with a truncated comment period in February.

**Recommendation: BCBSA and Plans request that CMS propose the changes with supporting documentation to the CMS-HCC risk adjustment model through formal notice and comment rulemaking, providing stakeholders with 60 days to comment.**

2. Alternatively, CMS Should Release More Information In December 2015, Prior to the Publication of the Advance Notice in February 2016.

If CMS does not use notice and comment rulemaking, as recommended above, to propose changes to the CMS-HCC risk adjustment model, BCBSA and Plans strongly urge CMS to release additional

information about the proposed changes in December before the Advance Notice is published in February 2016.

As stakeholders noted on the November 10, 2015 stakeholder call with CMS, the Risk Adjustment Memorandum does not provide enough information to allow for a full analysis of the proposed changes and their potential impact on revenue and operations. BCBSA and Plans understand that CMS may not have yet finalized the all aspects of proposal or determined, for example, the relative factors or the coefficients for the revised CMS-HCC risk adjustment model. We appreciate the need for CMS to ensure the accuracy and completeness of these figures in advance of releasing. However we urge CMS to make the information publicly available as soon as possible. Plans also request that CMS provide the disease interaction terms of the revised model, confirmation as to whether the HCCs within the model will be changed, an industry impact assessment demonstrating the global effect of the proposed changes, and the R2 values and other measures of prediction power for the current and proposed model variations.

This information – especially the industry impact analysis – is critical to Plans’ ability to evaluate CMS’s proposals on the risk scores of each of the identified populations, including the non-dual eligible beneficiary population. CMS notes in the Risk Adjustment Memorandum that “the community segment of the 2014 model predicts fairly accurately for non-dual eligible beneficiaries.” Despite the “fairly accurate” predictions, however, Plans anticipate that CMS’s proposal extends to the non-dual eligible beneficiaries and, as such, need to evaluate the potential implications of the model for this population. More information is needed for this assessment.

Conducting an industry impact analysis will also help test the proposed methodology and highlight for CMS and stakeholders any complications in the various versions of the CMS-HCC risk adjustment model. BCBSA and Plans note that the proposed changes introduce significant complexity in payment systems and various data transmissions. Before the proposed changes impact plan payment, testing should be undertaken to confirm the accuracy of the changes and identify and address any unintended effects.

If CMS proceeds with its plan to hold this additional detail until the release of the Advance Notice, stakeholders will have only 15 days to process the information and provide comments. This window does not provide enough time to analyze the changes and their potential impact on payment and operations – especially considering that CMS expects to release details about six different variations of the CMS-HCC risk adjustment model corresponding to six different beneficiary populations. As such, BCBSA and Plans encourage CMS to release additional detail – including the relative factors and the coefficients – regarding each of the six variations of the CMS-HCC risk adjustment model as soon as possible. This will allow Plans to begin to assess the proposed changes and their potential implications so that Plans are in a position to provide CMS with meaningful comments in response to the Advance Notice.

**Recommendation: If CMS is unable to provide information before the publication of the Advance Notice, BCBSA and Plans recommend that CMS consider whether implementation of any changes should be postponed until Contract Year 2018 or later so that stakeholders have adequate opportunity to comment on the proposals. Alternatively, these changes should be phased in to allow stakeholders more time to adapt to the changes.**

3. CMS Should Consider Whether a Monthly Adjustment to a Beneficiary’s Population Categorization is Administratively Feasible.

As proposed in the Risk Adjustment Memorandum, CMS intends to develop six different community segments of the CMS-HCC risk adjustment model, each of which corresponds to a different beneficiary

population: full benefit dual aged, full benefit dual disabled, partial benefit dual aged, partial benefit dual disabled, non-dual aged, and non-dual disabled. Recognizing that beneficiary status can change during the payment year, even month by month, CMS proposes to “determine the appropriate risk score for each monthly payment, based on a beneficiary’s status in the payment month.” Although BCBSA and Plans appreciate that CMS may have proposed this method in an effort to calculate the most accurate risk score possible, we have concerns about accuracy of the data CMS would use to implement this approach. For example, Medicaid eligibility for an individual may vary more frequently than institutional status. A month-to-month adjustment increases volatility in payments and also increases the potential for incorrect payments and retroactive reconciliations. It seems somewhat unlikely that an individual’s health status would dramatically change in the same time period during which such individual moves among the proposed six population categories or from dual to non-dual status. Accordingly, we recommend CMS consider whether the Agency should apply to an individual, for the duration of a calendar year, the status associated with the most significant segment for which such individual becomes eligible, rather than attempting to adjust the segment assignment on a monthly basis. Such an approach would seem to mitigate several data-related issues and provide consistency in payment levels to MA Organizations.

**Recommendation: Given that the data CMS uses will directly impact the payments made to MA Organizations, BCBSA and Plans recommend that CMS carefully consider whether this proposal is administratively feasible and how CMS will ensure that the data is accurate.** For example, BCBSA and Plans are unaware of a data feed that exists between CMS and the states that allows CMS to get monthly updates regarding state Medicaid enrollment data. Moreover, we are concerned that any such data may not be current and could be inaccurate in some cases, as many beneficiaries are determined to be eligible for Medicare and/or Medicaid on a retroactive basis. Based on statements made on the November 10, 2015 call with CMS, BCBSA and Plans understand that CMS has not yet developed a plan to address the challenges created by this retroactive eligibility. BCBSA recommends that CMS create and submit such a plan for comment.

**Recommendation: BCBSA and Plans request that CMS hold MA Organizations harmless from the results of any inaccuracies in the data CMS obtains and uses.** The changes to the CMS-HCC risk adjustment model represent a CMS initiative that is based on data over which MA Organizations have no control. Accordingly, MA Organizations should not be held accountable for any inaccurate data or inaccurate payments based on this data. Additionally, Plans request the ability – but not the obligation – to verify and submit suggested changes to the data CMS uses to determine the appropriate community segment of the CMS-HCC risk adjustment model for each beneficiary.

If the data for these adjustments depend on new data sharing arrangements with states, we request more information on the timeliness of these data files and whether operational systems have been tested and will be in place by January 1, 2017. We also suggest a test period with Plans so there is a clear understanding on how these new payment categories will be accounted for and what reconciliation or retroactivity might be associated with these adjustment to assure Plans will receive accurate payments.

#### 4. CMS Should Consider Whether Similar Changes to the RxHCC Model Are Appropriate

Several Plans have questioned whether the RxHCC model reflects similar issues with respect to accuracy of the assigned risk score and whether corresponding adjustments should be made to the RxHCC model, in order to maintain consistency among the Medicare Advantage and Part D Programs.

BCBSA and Plans do not have a recommendation on whether to adopt such changes, but do suggest to CMS that further consideration of such an issue by CMS – and an opportunity for Plans to weigh in on this issue when more data is available – would be an appropriate step to undertake.

## **14. Blue Cross Blue Shield of Michigan**

Blue Cross Blue Shield of Michigan (BCBSM) appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) in response to the Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017.

BCBSM has more than 375,000 members enrolled in our Medicare Advantage and Part D plans and has an overall rating of 4 stars. Our HMO, Blue Care Network (BCN), has approximately 71,000 members and an overall rating of 4.5 stars. With many years of combined individual and group Medicare experience, we look forward to continuing to partner with CMS to improve health, member outcomes and care provided in the Medicare program.

This letter highlights our key concerns and recommendations in response to CMS Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017. The proposed changes aim to address the concerns about the accuracy of the CMS-Hierarchical Condition Category (HCC) risk adjustment model for predicting costs of dual eligible beneficiaries. Presently, the CMS-HCC model uses a single adjustment factor for dual eligibility status. CMS proposes to replace this single adjustment factor and instead use six separate models for community dwelling beneficiaries based on different categories of dual eligibility and reason for entitlement (aged or disabled).

BCBSM recognizes the issues around predicting costs of dual eligible beneficiaries and commends CMS for its efforts to try to address them. However, BCBSM has concerns about 1) the potential impact of the changes on other populations; 2) gaps in the information provided by CMS; 3) use of Medicare fee-for-service (FFS) data instead of Medicare Advantage encounter data; and 4) the operational challenges the proposed changes may present. These concerns are described in further detail below.

### **Potential Impact on Other Populations**

CMS acknowledges that the changes to the CMS-HCC model have been proposed to “improve the predictive ratios for full benefit and partial benefit dual eligible beneficiaries in the community.” Yet, the proposed changes will not only affect the predictive ratios for full benefit and partial benefit duals, but are expected to also affect the predictive ratios for non-dual eligible beneficiaries. This is true despite the fact that CMS indicates the predictive ratio for the non-dual community segment is 1.015, and CMS acknowledges that “the community segment of the 2014 model predicts fairly accurately for non-dual eligible beneficiaries.”

BCBSM is concerned that the proposed changes to the CMS-HCC model go beyond their stated intent and may negatively affect a model that “predicts fairly accurately” for non-dual eligible beneficiaries. Since CMS indicates the predictive ratio for dual eligibles is less accurate (0.957) than for non-dual eligibles (1.015), we encourage CMS to consider limiting changes to rebalancing the partial and full dual eligible community segments only.

### **Additional Information Needed**

BCBSM greatly appreciates CMS’s efforts to make information about a significant proposed change in the risk adjustment model available in advance of the CY 2017 Advance Notice. However, we believe additional information is needed in order to sufficiently analyze impact and provide meaningful feedback to CMS. We urge CMS to provide the information outlined below as soon as possible and in

advance of the CY 2017 Advance Notice so that we have more than 14 days to analyze the impact of six different variations of the CMS-HCC risk adjustment model.

**Relative Factors.** BCBSM requests that CMS provide the CMS-HCC model relative factors for each proposed segment. Without these key figures, Medicare Advantage plans are unable to appropriately model and assess the proposed changes to the CMS-HCC risk adjustment model. CMS indicates it will provide the relative factors in the CY 2017 Advance Notice. However, given the complexity and scale of these changes, BCBSM requests that CMS provide the relative factors at an earlier date to provide plans with sufficient time to model the changes.

**Statistical Methodology.** BCBSM also requests that CMS provide the R2 values, as well as any other measures of prediction power that CMS has studied, for the models under each of the proposed segments, as well as the same measures for the current model. The statistical measures of the models will be helpful to assess how well each model is performing in predicting cost and explaining variability, and how much improvement is gained by separating one community based model into six independent models.

Additionally, BCBSM is concerned that CMS may be introducing additional volatility in payment levels by segmenting and calibrating the model on relatively smaller populations of community dwelling dual eligible beneficiaries.

**Industry Impact.** As stated above, BCBSM has concerns that the proposed changes will impact the non-dual eligible population, despite the fact that the current model predicts “fairly accurately” for this population and the stated intent of the proposed changes is to improve the predictive ratios for full benefit and partial benefit dual eligibles only. Because non-duals represent a much larger portion of Medicare Advantage enrollees than dual eligibles, we are hoping CMS can provide information about the expected industry impact in total. This information is particularly important if CMS is unable to release the relative factors in advance of the CY 2017 Advance Notice.

**Use of Recent Medicare Advantage Encounter Data vs. Fee-For-Service (FFS) Data.** Per BCBSM’s review of the October 28, 2015 HPMS memo, it appears CMS utilized Medicare FFS data from 2011-2012 to model the predictive ratios and mean actual costs for each segment.

Understanding the inherent differences in membership makeup between Medicare FFS and Medicare Advantage beneficiaries, BCBSM urges CMS to reconsider their use of FFS data and recommends using Medicare Advantage encounter data instead. It is our understanding that the majority of dual eligibles are enrolled in FFS, and that those that do enroll in Medicare Advantage plans may have a different risk profile and utilization experience than their FFS counterparts. In the alternative, BCBSM suggests that CMS uses Encounter Data from a more recent payment year.

### **Operational Concerns**

BCBSM would also like to express concern about anticipated operational issues caused by the proposed changes. Specifically, the monitoring, tracking and reconciliation of the status of members in a CMS-HCC model with six (6) separate community segments where “dual status in the community segments would be concurrent” will be overly complex and administratively burdensome.

BCBSM looks forward to continuing its partnership with CMS in the Part C and Part D programs. Thank you again for the opportunity to provide feedback on the proposed changes.

## 15. BlueCross BlueShield of Western New York

The analysis we did shows that we have MLR's over 100% for

- Non-Dual Disabled
- Full Dual Disabled
- Partial Dual Disabled

With the new proposal the Non-Dual Disabled and Partial Dual disabled would get worse with the new MLR proposal. **We found that the net affect of the change would be negative for us and because of this reason we would prefer to keep the current model.**

## 16. Boston Center for Independent Living

Disability Advocates Advancing Our Healthcare Rights (DAAHR), a coalition of over 20 disability, elder and healthcare advocacy organizations in Massachusetts is writing in support of CMS's proposed changes to the Medicare risk adjustment model. The need to implement the changes to risk adjustment is urgent.

The current CMS risk adjustment model does not accurately account for the needs of the most vulnerable, sickest dual eligibles nor does account for pent-up unmet need in the dual eligible population among people with complex needs. As a result, the continuity of care and access to services of thousands of Massachusetts dual eligibles ended this September 30 with the collapse of Fallon Total Care. If not for CMS' critical intervention and the intervention of others, thousands of more lives in Massachusetts would have been negatively impacted by the current risk adjustment model.

The proposed changes are an important move forward in addressing the needs of full dually eligible beneficiaries. The proposed risk adjustment changes are in keeping with principles of the Affordable Care Act in two key ways: first by redistributing resources to plans addressing the needs of high-risk populations and second, by providing increased protection against adverse selection by spreading financial risk across more markets.

These changes are central to supporting programs like One Care in Massachusetts, addressing the needs of full dual eligibles under 64 with the most complex and costly medical, behavioral health and LTSS needs. The suggested changes would address basic flaws in risk adjustment at the national level that destabilized One Care in Massachusetts and would potentially all other dual eligibles demonstrations across the country.

Bending the cost curve requires investment in care for dual eligibles under the age of 64 with high-cost complex physical, behavioral health and other conditions. Appropriate risk adjustment is key to achieving this aim. In this regard, the current recommendations do not address risk of providing care for people with many mental health disorders including depression, personality disorders etc. It is hoped that eventually CMS will fine-tune risk adjustment to more appropriately reflect the costs of caring for these populations.

DAAHR urges CMS move forward with the recommended adjustments because they are actuarially sound and essential to the development of innovations to improve health care access and outcomes of vulnerable and costly populations. It should be added that proposed regulatory changes may not go far enough, but they are an important start in moving the needle towards system sustainability and improved care for dual eligibles with intensive medical, behavioral health and LTSS needs.

## 17. CAPG

We appreciate the opportunity to comment on the Proposed Changes to the CMS-HCC risk adjustment model for Payment Year 2017. CAPG represents 200 multi-specialty physician organizations across 40 states, Washington, DC, and Puerto Rico. Our physician members participate in value-based payment models in Medicare Advantage and traditional Medicare. CAPG members have successfully operated under alternative payment models for decades.

### **Background**

CMS is developing a revised CMS-HCC model that creates separate community segments based on dual eligibility (“duals”) and aged/disabled status in a payment year. CMS says that its analysis shows that revisions to the model would improve risk adjustment accuracy for full benefit duals, partial duals, and non-dual beneficiaries. The updated model is intended to result in more appropriate relative weights for HCCs because the relative weights reflect the disease and expenditure patterns of community segments.

### **Concern about Medicare Advantage Funding Stability**

Medicare Advantage is growing in popularity and enrollment among seniors, particularly baby boomers. Today the program makes up nearly one-third of Medicare enrollment. The combination of appropriately aligned financial incentives and the program’s flexibility to innovate to improve care make Medicare Advantage an ever-growing, popular option for our patients. Medicare Advantage allows physicians to improve care delivery systems, deploy primary care-led teams, and focus on prevention and wellness.

In addition to being a high value option for seniors, Medicare Advantage plays a critical role in delivery system reform. While physician relationships with plans overall are on the same trajectory, moving from fee-for-service to alternative payment models, Medicare Advantage has the distinct advantage of having “reached the destination” when it comes to risk-bearing relationships with providers, in some regions, e.g., California where the capitated, delegated model is the norm.. While not every relationship between a plan and a physician is a risk-bearing arrangement, Medicare Advantage is the one place where two-sided risk bearing relationships between payers and providers not only exist, but succeed today.

A recent PwC report shows that “early ACO formation often has occurred in communities with successful Medicare Advantage programs, piggybacking onto the established market norms. Data provided by CMS show clusters in communities such as healthcare-rich New England, where ACO and bundled payment efforts co-exist with a high density of Medicare Advantage patients.” These findings support our recommendation that CMS take a whole Medicare (MA and traditional Medicare) approach to delivery system reform. Investments in Medicare Advantage translate to a stronger delivery system overall and advancements in the very “alternative payment models” CMS seeks to build and spread in traditional Medicare.

Despite its strengths and popularity, in recent years, the Affordable Care Act has imposed significant reductions in payments on the Medicare Advantage program. When the Medicare Advantage program is cut, these reductions are passed through directly to capitated physician organizations participating in the program where the bulking of the funding is ultimately directed. Often, these cuts are scarcely felt by the MAO that retain only 15% of the funding under our MLR rules.

Therefore, while we are pleased CMS is addressing one factor in the underpayment for dual eligibles, we remain concerned about the overall funding picture for Medicare Advantage and encourage the agency to maintain stable funding for Medicare Advantage in the 2017 Rate Notice and Call Letter.

### **CAPG Comments on CMS's Proposal**

CAPG is pleased that CMS has acknowledged the underpayment for dual eligible populations in the current risk adjustment methodology. CAPG members strive to provide high quality care to their patient populations. In the case of duals and other complex patients, this often requires heightened use of resources to treat multiple chronic conditions, behavioral, social and other healthcare factors. We are pleased to see CMS acknowledge the additional resources that are necessary to provide the highest quality care to populations that are among the most vulnerable.

We remain concerned about the potential impact of this proposal on partial duals. We recommend that CMS perform a deeper analysis of the partial dual population, to explain the difference in the impact of the current HCC model, prior to implementing the new policy. This analysis will provide health plans and our physician members with greater insight into the true needs of the partial duals population, and how it differs from the full duals population.

We also believe that there are still well-documented inaccuracies in the Stars Rating Methodology that adversely affect health plans that enroll both partial and full duals, and the physicians with whom they share risk. We encourage CMS to continue to examine the Stars Program as a source of inaccuracy in the payment model for this population.

### **Conclusion**

We are encouraged by CMS's efforts to improve the accuracy of Medicare Advantage payment. We believe that improved accuracy in risk adjustment for dual eligible beneficiaries will enhance the ability of health plans and our members to provide the high quality care that characterizes the Medicare Advantage program to greater numbers of these most vulnerable segments of the Medicare beneficiary population.

We urge CMS to dig deeper into the causes behind the differences in predictive power that CMS has discovered in the application of the current HCC methodology to different subsets of the Medicare population, and to publicize the findings to assist all segments of the health care system to better meet the needs of these subsets.

And we recommend further testing of alternatives to the current quality rating system for dual eligibles, in recognition of the impact of poverty on quality metrics. And we believe that improvements to quality scoring and risk scoring should be implemented in tandem.

## **18. CareOregon**

Thank you for this opportunity to comment to the Centers for Medicare and Medicaid Services (CMS) in response to CMS' proposed changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017. For the reasons explained below, CareOregon is in full support of the proposed changes.

CareOregon is a non-profit, tax-exempt 501(c)(3) health care company that provides the Medicaid program to approximately 250,000 Oregonians throughout the state. CareOregon is also the parent company for HealthPlan of CareOregon, Inc., under which there are two Medicare Advantage Prescription Drug (MA-PD) plans. CareOregon's largest plan is a Dual Special Needs Plan (D-SNP) which



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serves approximately 10,000 individuals eligible for both Medicare and Medicaid. CareOregon's smallest MA-PD plan serves approximately 2,000 low income Oregonians on the verge of special needs classification; much of this population is Low Income Subsidy (LIS) eligible. Below are some facts about that makeup of CareOregon's MA-PD population:

<b>Geographic Distribution</b>	<b>Demographics</b>	<b>Health Conditions</b>	<b>Mental Health/Substance Abuse</b>	<b>Utilization –Top 3</b>
9 counties 83% metro (3 counties) 17% non-metro (6 counties)	44% under age 65 57% Female 12% over the age of 80	11% Congestive Heart Failure 16 % Chronic Obstructive Pulmonary Disease 30% Diabetic	10% Schizophrenia 7% Bi-Polar 12% Chronic Mental Illness 25% Substance abuse disorders (D-SNP only)	31.5% Rx Costs 25.5% Inpatient Care 15% Outpatient and ER Costs

As the table above makes clear, CareOregon is well acquainted with the challenges associated with providing care to the vulnerable population that is eligible for both Medicaid and Medicare. We know what resources are necessary to adequately coordinate care for this at-risk group of Oregonians, and we will continue to invest in the internal infrastructure necessary to consistently improve the quality of care that this population receives.

CareOregon supports the proposed HCC-Risk Adjustment model because we believe that this model more accurately identifies the risk associated with the population that we serve. Adequate assessment of the CareOregon MA-PD population's risk will have a direct impact on the financial resources that can be reinvested into efforts to improve the quality of health care we provide to this population. Specifically, CareOregon's MA-PD population would be affected by the proposed model as follows:

<b>MAPD Population</b>	<b>Nov 2015 Members</b>	<b>Risk Score</b>	<b>CMS Predictive Ratio</b>	<b>Estimated New Risk Score</b>	<b>Percent Change</b>
Full Dual Aged	5,114	1.400	0.892	1.570	12.1%
Full Dual Disabled	3,989	1.164	0.947	1.229	5.6%
Non Dual Aged	417	0.956	1.012	0.945	-1.2%
Non Dual Disabled	144	0.974	1.042	0.935	-4.0%
Partial Aged	557	1.300	1.123	1.158	-11.0%
Partial Disabled	486	1.125	1.072	1.049	-6.7%
Not impacted	1,141	1.250	n/a	1.250	0.0%
<b>Total</b>	<b>11,848</b>	<b>1.269</b>		<b>1.354</b>	<b>6.7%</b>

As the table above makes clear, CareOregon's target MA-PD population are those Oregonians that are fully eligible for both Medicaid and Medicare. We believe that the proposed model represents a

significant leap forward in efforts to improve Medicare Advantage for all populations. CareOregon is appreciative of this effort to more closely align our payments to the risk associated with caring for this population and fully supports the CMS-HCC Risk Adjustment Model for Payment Year 2017. Please do not hesitate to contact our organization should your agency need more data or information to support this effort.

## **19. CarePartners PACE**

This constitutes the response of CarePartners PACE to CMS' request for comment on the proposed changes to the HCC risk adjustment methodology.

### **Background:**

CarePartners PACE is a Program of All-Inclusive Care for the Elderly that has operated in Asheville, NC since March of 2015. We serve 52 individuals with significant complex chronic conditions and functional or cognitive impairment. All of our participants meet the state's definition of requiring a nursing home level-of-care.

### **Comments**

1) CarePartners PACE believes that developing risk factors for six distinct subpopulations of Medicare beneficiaries to acknowledge the impact of Medicaid eligibility status, along with institutional vs. community residence, will improve the accuracy of the risk adjustment system. CarePartners PACE supports the use of the subpopulations; distinct risk factors for establishing payments to PACE organizations. CarePartners PACE notes that approximately 91% of our enrollees are fully dual- eligible for Medicare and Medicaid.

2) In addition to calculating risk factors for the six distinct subpopulations of Medicare beneficiaries, CMS requests comments on changing the current PACE HCC model (HCC v.21) to the 2014 model being phased in for MA plans (the "2014 model"). CarePartners PACE, as we have stated previously in response to CMS' 2013 advance notice of payment when it initially proposed the 2014 model, strongly recommends retaining the current PACE HCC model (HCC v.21) for PACE organizations. Shifting PACE to the 2014 model will reduce the performance of the risk adjustment model for PACE enrollees relative to the model that is currently in place.

The Evaluation of the CMS-HCC Risk Adjustment Model completed for CMS by RTI and released in March, 2011 assessed the predictive ratio of the CMS-HCC risk adjustment model v.21 relative to an earlier version, v.12. The evaluation found that v.21 accurately predicts costs for Medicare beneficiaries and, in particular, significantly improved model performance over v.12 for beneficiaries of dementia.

Nearly half (44.8%) of all PACE enrollees have dementia, as of August, 2015. The HCCs (51 and 52) for beneficiaries with dementia that are included in v.21 and are related to its improved predictive value in comparison to v.12 are not in the 2014 HCC model. Because of the significance of dementia in the PACE enrollee population, we provide detailed comments on this condition and the impact of its removal from the HCC risk adjustment model below.

Further reducing the 2014 HCC model's accuracy when applied to PACE is its lack of HCCs that support the identification of interactions between early stages of kidney disease and congestive heart failure. Approximately 31% of PACE enrollees have a diagnosis of CHF, and of these 38% of PACE enrollees have a diagnosis of CHF, and of these 38% are diagnosed with an early stage kidney disease (HCC 138, 139, 140 or 141). We have estimated that the 2014 HCC model would reduce the average HCC score for PACE beneficiaries with congestive heart failure and early stage kidney disease by 20%.

In combination, the 2014 HCC risk adjustment model results in a significant degradation of the CMS-HCC risk adjustment model's predictive value for the large majority of PACE enrollees.

3) The CMS-HCC risk adjustment model for PACE enrollees needs to include dementia.

Because of the significance of dementia for the cost and care of PACE participants, the CMS-HCC risk adjustment model for PACE needs to include HCCs for dementia diagnoses. As noted earlier, approximately 45% of PACE participants are diagnosed with dementia, as indicated by the percent triggering either HCC51 or HCC52 for dementia in the CMS-HCC risk adjustment model currently applied to PACE (v.21). Removal of dementia related HCCs from the risk adjustment model significantly reduces the predictive ratio of the model for these PACE enrollees and, as a result, will undermine the financial sustainability of PACE programs.

Risk adjustment without HCCs for dementia results in substantial under prediction of the costs of care for enrollees with dementia, who comprise a large proportion of PACE organizations' total enrollment.

Referring to the Evaluation of the CMS-HCC Risk Adjustment Model that CMS released in March 2011, RTI compared predictive ratios for HCC chronic disease groups and concluded that v.21 of the CMS-HCC model was far superior to v.12 in predicting costs for beneficiaries with dementia. For beneficiaries with dementia, v.21 (with HCCs for dementia) of the model achieved a predictive ratio of 1.000 compared to 0.858 for v.12, which like the 2014 model used for MA plans lacks HCCs for dementia. This indicates that predicted costs for beneficiaries with dementia under v.12 are essentially 14% lower than actual costs. Based on historical diagnostic data, CAREPARTNERS PACE's comparison of PACE organizations' mean HCC scores that are, on average, 21% lower than v.21. We are deeply concerned that exclusion of dementia HCCs in the 2014 model leads to substantial underpayment for PACE enrollees with dementia. These individuals account for almost half of all PACE enrollees.

Failure to recognize dementia related costs is not consistent with CMS efforts to serve more people needing long-term services and supports through health plan options.

As CMS and states seek to enroll more people needing long-term services and supports in managed care options, the impact of under predicting costs associated with dementia will be broader than PACE. While for most Medicare Advantage plans the current prevalence of dementia is low, resulting in a minimal financial loss associated with the removal of dementia as a risk factor, the impact on PACE and other emerging options for people who need long-term services and supports, a large proportion of whom will have dementia, will be much greater.

4) Retaining the current PACE HCC model (v.21) will reflect the costs of preventing early stage pressure ulcers.

A shift to the 2014 model would eliminate HCCs for pressure ulcers categorized as stage 1 or 2. Without these HCCs, the risk adjustment model would not take into consideration the care planning and treatment required in order to prevent these ulcers from escalating to a stage 3 or 4 ulcer. In the frail population served by PACE, individuals' compromised skin condition along with coexisting medical conditions such as diabetes and peripheral vascular disease often lead to the development of pressure ulcers. The early interventions PACE organizations provide avoid lower stage ulcers from progressing to stage 3 or 4 ulcers. If not prevented, these higher stage ulcers can require high cost procedures, hospitalizations and in some cases may lead to death. The HCC model for PACE should recognize, and incentivize, the investment in prevention made in caring for people with stage 1 and 2 ulcers.

**Recommendations:**

**1. Retain the current v.21 of the CMS-HCC risk adjustment model for PACE**

CARE PARTNERS PACE strongly recommends that CMS retain the current v.21 CMS-HCC risk adjustment model used for PACE payment. This HCC model recognizes the importance of dementia in predicting Medicare costs. In addition, this model appropriately reflects the costs of care for PACE participants with early stage pressure ulcers and early stage kidney disease that is comorbid with congestive heart failure. The combination of PACE county payment rates, the current v.21 CMS-HCC risk adjustment model and frailty adjustment generates appropriate payment for our high cost population of Medicare beneficiaries.

This assessment is based on part on an analysis, previously shared with CMS by the National PACE Association, undertaken in response to CMS' implementation of the frailty adjustment model applied to PACE beginning in 2008. The study identified a PACE-like population from among respondents to the National Long Term Care Survey (NLTC) and compares their observed costs in FFS to the costs predicted by the v.12 CMS-HCC risk adjustment model and revised frailty adjustment model. The study concluded their payments were substantially under predicted. A significant proportion of this under prediction was addressed by implementation of the v.21 model in CY2012 and further addressed by implementation of the recalibrated frailty adjustment model in CY2013. Applying the 2014 model to PACE will undo the improvements in the risk adjustment methodology for PACE that have been achieved to date.

**2. Apply distinct risk factors for the subpopulations of Medicare beneficiaries described in the request for comment to the calculation of payments for PACE organizations.**

We concur with CMS that dual-eligible status is a strong determinant of costs to the Medicare program. Establishing distinct risk factors for populations based on this eligibility status along with institutional vs. community residence status, will improve the accuracy of the payment methodology for PACE.

In addition to the improved performance relative to the MA 2014 CMS-HCC risk adjustment model, retaining the v. 21 model offers the benefit of payment stability for PACE organizations. As comparatively small, not for profit organizations, PACE programs are particularly compromised in their ability to make financial commitments regarding developing and operating PACE by stark annual changes in Medicare's payment methodology.

## **20. CareSource**

CareSource greatly appreciates the opportunity to offer comments regarding the Centers for Medicare and Medicaid Services (CMS) Proposed Updates to the CMS-Hierarchical Condition Category (HCC) Risk Adjustment Model for Payment Year 2017.

CareSource is a leading non-profit managed care company based in Dayton, Ohio which has been meeting the needs of underserved populations for more than 25 years. CareSource MyCare Ohio is a MMP health plan that combines both Medicare and Medicaid into a single benefit for dually eligible beneficiaries. As CareSource manages the full continuum of benefits for these members, providing coordination of acute care, long-term care services, behavioral health services, and physical health services, it is a necessity that the allocation of resources accurately reflects population dynamics that are unique to MMPs.

It is an established industry position that the Medicare Advantage (MA) risk-adjustment system under-predicts the costs of full-benefit dual eligible members, and CareSource applauds CMS for taking steps to address this fundamental system limitation. Dual-eligible members experience greater functional

impairments than traditional Medicare beneficiaries, and have more pronounced acute and long term care needs. By acknowledging that cost differences exists between full-benefit and partial-benefit duals and-disabled and aged individuals, CMS is addressing long-standing misalignments in reimbursement for complex, vulnerable populations.

To assure that fully integrated programs remain viable, CareSource believes it is imperative that risk modeling be adjusted to more accurately reflect the scope and intensity of needs for dual eligible members. For this reason, CareSource fully supports the CMS proposal to improve the accuracy of risk-adjustment for dual eligible members, as well as the recommendation for implementation of the proposed changes in 2017 not only for dual eligible members in Medicare Advantage Plans but also for duals, like those we currently serve in our MyCare program, in demonstration programs. CareSource also believes the opportunity exists in 2016 to allow retro- active payment adjustments to account for the current model's under-prediction for full-benefit dual eligible members. Success in integrated models of care is predicated upon the MMP's ability to effectively coordinate a wide array of services and resources for each beneficiary. Rate inadequacy based on an outdated Risk Adjustment Model impedes the ability of the MMP to enhance benefits, develop innovation, and increase capacity to provide the proactive individualized services that are necessary to support at-risk populations. CareSource also believes that the revised model will provide significant value in our ability to understand these members with complex healthcare needs and more accurately provide support based on their expected future costs.

CareSource encourages CMS to continue its evaluation of the HCC model with a focus on expansion into community-based care segments. CareSource would also advocate for the additional expansion of the model to include mental and behavioral health components of risk; the scope, duration, and intensity of which are also present at higher rates for dual-eligible members. Thank you once again for the opportunity to comment and for your consideration.

## **21. Centene Corporation**

Thank you for the opportunity to comment on the memorandum issued by the Medicare Plan Payment Group on October 28, 2015 regarding the Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017. The memorandum proposes changes to improve the way that the MA risk-adjustment system determines payments for those beneficiaries eligible for both Medicare and Medicaid (dual eligibles). Centene commends CMS for recognizing that problems exist in the CMS-HCC Risk Adjustment Model, and we stand ready to work with you as you further refine the model.

### **I. Overview of Centene Corporation**

Founded as a single health plan in 1984, Centene Corporation (Centene) has established itself as a national leader in the healthcare services field. Today, Centene's managed care organizations work with over 4.8 million members across 23 states. Centene provides health plans through Medicaid, Medicare and the Health Insurance Marketplace and other Health Solutions through our specialty services companies. We believe quality healthcare is best delivered locally. Our local approach enables us to provide accessible, high quality and culturally sensitive healthcare services to our members.

Centene currently operates Dual Eligible Special Needs Plans (D-SNPs) in seven states: Ohio, Wisconsin, Arizona, Texas, Georgia, Oregon and Florida. These seven states have a combined membership of approximately 9,000 D-SNP members. In addition, we are participating in the Financial Alignment Demonstrations in Ohio, Texas, South Carolina, Illinois, and Michigan. Our combined membership in the demonstrations is approximately 27,000. Centene has a history of serving low income and vulnerable

populations. That is demonstrated by our commitment to the dual eligibles through our D- SNP products as well as our participation in the demonstrations.

## II. CMS's proposal to modify the CMS-HCC Risk Adjustment Model for Payment Year 2017

The memorandum recognizes the Medicare Payment Advisory Commission's (MedPAC's) concerns over the accuracy of the CMS-Hierarchical Condition Category (CMS-HCC) risk adjustment model for predicting the costs of dual eligibles. MedPAC's specific concern is that beneficiaries with full-dual eligibility status incur significantly higher costs than beneficiaries with partial-dual eligibility (those whose Medicaid benefit consists only of assistance with Medicare premiums and, in some cases, Medicare cost sharing). Currently, the CMS-HCC system uses a single adjustment factor for dual eligibility status that is applied to both full- and partial-benefit dual eligible beneficiaries.

In place of this single adjustment, CMS proposes for 2017 to use six separate models for community dwelling beneficiaries based on different categories of dual eligibility and reason for entitlement (aged or disabled). CMS would continue to use a separate model for beneficiaries who have been in an institution for 90 days or longer. The CMS-HCC risk scores for community-dwelling beneficiaries would be modeled separately for each of the following six groups:

1. Full benefit dual aged;
2. Full benefit dual disabled;
3. Partial benefit dual aged;
4. Partial benefit dual disabled;
5. Non-dual aged; and
6. Non-dual disabled.

CMS asserts that each of the six models will produce relative scores for each disease category, reflecting CMS's finding that disease is often treated differently for beneficiaries in different groups.

## III. Centene's Comments

At the outset, Centene is pleased that CMS has recognized the underpayments for dual eligible beneficiaries in the current CMS-HCC model. Through a number of forums over the last several years, both individually and through our industry trade associations, we have encouraged CMS to revise the CMS-HCC model to more accurately measure the risk and medical expense of the dual-eligible population in both the Medicare Advantage Dual-Special Needs Plan (MA D-SNPs) programs and the Medicare-Medicaid integration programs (MMP) (these programs are demonstrations out of the Medicare-Medicaid Coordination Office under the Financial Alignment Initiative). Centene also commends CMS for its CY 2016 Medicare A/B adjustments and its commitment to ensuring better alignment between payments for MMP and FFS full benefit dual eligible beneficiaries. Therefore we are generally supportive of CMS' proposed revisions to the model, but believe the changes are only incremental and further refinements are needed.

In the short-term, we have the following recommendations:

Given that CMS acknowledges that underpayments result from the model, we would also suggest that CMS consider making the model adjustment applicable to PY 2016. The PY 2016 adjustment could be in the form of either a mid-year true-up in August 2016 or final true-up in July 2017 so another year of underfunding does not go by.

We note there was limited documentation provided in the memorandum and as a result it is difficult to simulate potential results with certainty. We would like to work with you to gain further information as to whether CMS evaluated the HCC model coefficients to determine the need for weighting adjustment on the same CMS-HCC across the proposed six cohorts. We are interested in whether that would uncover underlying clinical intensity differences on the same illness.

In the spirit of building a longer term and sustainable financing model for all programs involving dual eligibles, we respectfully offer the following suggestions for the future of the CMS-HCC risk adjustment model beyond 2017:

MA risk adjustment does not operate in a vacuum because payment adjustment depends on other processes (particularly operational and eligibility processes). A holistic approach must be taken to ensure implementation is adequate. We are particularly concerned about the timing and timeframes for designation of a beneficiary being considered "dual eligible". One suggestion to consider is that assignment of Medicaid status on a concurrent (payment year) basis better reflects the member's true status and aligns funding to match current expected resource usage.

Part D funding should also incorporate these risk adjustment model changes in order to globally correct program underfunding. Full benefit dual eligible members consistently have under-treated health conditions that require more aggressive pharmacy care management to both resolve the historical under-treatment and develop clinically-appropriate treatment plans.

The MMP program and programs that pair MLTSS and D-SNP models are substantially similar to the PACE program. All three programs should be receiving comparable rates to ensure that they operate on a level playing field to enable appropriate beneficiary choice.

Given the prevalence of mental health conditions in the dual eligible population, we respectfully suggest CMS look to improve the model for the future, including adding additional HCCs for mental health as well as adequately weighting those that are in place today.

Changes to the CMS-HCC risk adjustment model should also be applied to the Medicare- Medicaid demonstration programs.

Centene would be pleased to work with the agency to model the implications of these proposed adjustments on real plan data.

## **22. Cigna**

Cigna-HealthSpring welcomes the opportunity to respond to the Request for Information regarding proposed changes to the CMS-HCC risk adjustment model for payment year 2017. Cigna-HealthSpring does not support implementation of the proposed changes to the risk adjustment models and we ask CMS not to move forward with these changes. We urge CMS to address existing disparities in the Star ratings that disadvantage plans serving a large share of low-income, vulnerable populations before considering any changes to risk adjusted payments that may exacerbate the disincentive plans face in serving these populations.

Cigna-HealthSpring, a Cigna company, is one of the leading health plans in the United States focused on caring for the senior population, predominantly through Medicare Advantage (MA) and other Medicare and Medicaid products. Our focus on this market has allowed us to develop a unique approach to healthcare coverage for beneficiaries. We have a deep understanding of the needs and challenges facing both patients and physicians, and thus have developed a collaborative model that provides more access to high quality preventive care for our customers while supplying physicians what they need to deliver

that care. Specifically, Cigna-HealthSpring recognizes and rewards physicians for quality over quantity of care, and we provide extra nurse and technology resources so physicians can devote more time and attention to their patients. The result: healthier, more satisfied customers with lower medical costs.

Cigna-HealthSpring has always supported a risk adjustment model that pays as accurately as possible. Unfortunately, CMS' analysis of cost differences for full-benefit and partial-benefit dual-eligibles in the fee-for-service (FFS) population ignores three major forms of payment inaccuracy: 1) cost differences between full-benefit and partial-benefit duals reflect different utilization incentives for the two populations rather than true differences in clinical health care needs and costs; 2) the Stars payment bias that denies bonus payments to plans that are delivering high quality care under difficult circumstances; and 3) the total absence of any measure of quality in the FFS data used as the basis of risk adjustment.

The basis of CMS' proposal to change the risk adjustment model is that FFS data shows different cost profiles for full-benefit and partial-benefit duals. However, we believe that these differences do not reflect true differences in health care needs or costs for these populations. Rather, the observed differences reflect different cost sharing burdens that allow full-benefit duals to access care with no cost sharing burden, while partial-benefit duals may face cost sharing that poses a barrier to accessing care. As a result, full-benefit duals are likely to use more health care services than partial-benefit duals with the same or similar health care needs. Enrollment in MA evens out the differences in utilization incentives between the two groups.

With regard to the second inaccuracy, CMS' own research demonstrates that limitations in the Stars rating methodology disadvantage plans that serve a disproportionate share of dual-eligible or disabled members. Further, that research finds that the disparity in ratings exists for both partial- and full-eligible duals, with no meaningful difference between the two groups. CMS research also shows a clear disadvantage to plans serving a disproportionate share of disabled members. It is difficult to reconcile how CMS can say it sees clear disadvantages for plans that serve partial duals and disabled members, and then turn around and reduce payments for these members.

These plans are already facing payment disparities as a result of lower Star ratings, which can have dramatic payment consequences through lost benchmark bonuses and lower rebates. Most importantly, partial-dual and disabled members in these plans are losing access to the benefits and services that should accrue as a result of higher plan payments and rebates, but are instead being diverted to plans that serve only high-income, non-disabled members.

The third payment inaccuracy that this proposal ignores is the lack of any measure of quality or care management in the FFS spending data used as the basis for the risk adjustment model. CMS' estimate of relative spending for dual-eligible or disabled beneficiaries completely ignores the added spending required to help such members achieve better health. The spending Cigna-HealthSpring devotes to our Living Well Centers in low-income neighborhoods with large numbers of both partial- and full-eligible duals (and staffed with case managers, social workers, or high-risk pharmacists with the goal of providing added support to the social and medical needs of these members) is completely absent from the CMS risk adjustment model. The care management and chronic disease coordination programs we run to help our vulnerable populations maintain and improve their health is unaccounted for in the CMS risk adjustment model. Further, as the CMS research on Star ratings demonstrates, the need in these programs does not fall neatly along CMS' dual-eligibility definitions. Low-income and disabled members are high users of these services regardless of whether their income falls above or below 100 percent of the federal poverty level.



Statements from CMS leaders suggest that CMS believes this proposal is one part of addressing the bias against plans that serve low-income members that has been the topic of discussion and research over the past year.

However, these proposed changes do nothing to fix the disparity in Star ratings. Research from CMS and others has consistently shown that the bias exists in the Stars rating system; the fix must therefore be to adjust the Star ratings in some way to eliminate the disparity that comes from serving a disproportionate share of low-income beneficiaries.

Recommendation: In sum, the current proposal to modify the risk adjustment model does not help the situation with regard to the disadvantage of serving vulnerable populations, it makes it worse. We strongly urge that CMS not move forward with the proposal. CMS should instead focus on eliminating the disparity in Star ratings that reduces the incentive to serve vulnerable populations in the MA program.

In addition to our overall objection to the proposal, we have some specific concerns with how CMS would implement the proposed changes:

- This proposal would make the process of revenue and risk score projections over-complicated: Moving from a single community risk adjustment model to six different community models will make the process of projecting revenues and risk scores extremely complex. In addition, CMS' proposal to use the current Medicaid eligibility category, which can change on a monthly basis, makes it impossible to predict which model a beneficiary is likely to be assigned to at any given point during the year. If the different models have different risk weights for clinical and demographic factors, as CMS predicts, the result could be substantial shifts in expected risk-adjusted payment for a given individual throughout the year.
- Moving from using prior year Medicaid eligibility to current year eligibility would cause greater uncertainty: A related consideration is the lack of consistent data on the Medicaid eligibility status of plan members. We understand that reliable data on whether an individual qualifies for partial, full, or non-dual status in any given month often takes many months to determine. Member status can be changed retroactively. Cigna believes the lack of consistent, reliable data will make actual plan payments difficult or impossible to know. This is especially concerning given the large changes in payment between full and partial-benefit eligible members that CMS proposes. A plan could see its final risk-adjusted payment swing dramatically in the final reconciliation if the final Medicaid status of many members is in question. For Cigna-HealthSpring which serves a disproportionate share of dual-eligible beneficiaries, this is deeply concerning.

We appreciate CMS' goal of increasing payment accuracy, but do not believe these proposals will achieve that end. We strongly encourage CMS to reconsider its approach and work to address the Star ratings disparity by improving the accuracy of that program.

## **23. Commonwealth Care Alliance**

As you know, Commonwealth Care Alliance (CCA) is an integrated health system serving the comprehensive health care needs of dual eligibles in Massachusetts. We serve over 7,000 Medicaid-eligible seniors in our fully integrated D-SNP, known as Senior Care Options (SCO), which we have operated since 2004. We also serve over 10,000 disabled adults under age 65 in our One Care program, which opened in October 2013 as part of the Financial Alignment Demonstration.

Commonwealth Care Alliance sincerely appreciates CMS's commitment to examine the appropriateness of its risk adjustment model for full-benefit dual eligibles, particularly following the changes in the HCC model for 2016, which resulted in a 3.8% drop in our Part C risk scores: twice the national average. This change, combined with other factors, caused a 5.4% overall drop in our risk scores for 2016. We are greatly encouraged by the results of your analysis and appreciative of the opportunity to comment on CMS' proposed approach to addressing the underpayments confirmed by your analysis. **CCA strongly supports CMS' proposed approach**, as outlined in the October 28<sup>th</sup> memo. We believe this approach appropriately addresses confirmed underpayments and is a significant step toward properly reimbursing Medicare plans for needed and appropriate care for Medicaid eligible beneficiaries.

Specifically, we support CMS' decision to segment the Medicare Advantage population into six groups based on dual status (full, partial or non), and aged versus disabled status. We agree with CMS' findings that each group has a distinctly different cost profile, and appreciate the proposed correction to more accurately predict costs across all groups. We particularly appreciate early evidence suggesting that the revised risk adjustment model will make the biggest change for full benefit duals in the highest-cost deciles, where under payment has been most significant. Commonwealth Care Alliance serves only full benefit duals, and has disproportionate concentrations of the sickest and costliest full benefit aged and disabled duals. Thus, from our perspective, these changes are long overdue. We urge you to implement your proposed changes without delay or compromise.

As you work to further refine the model in advance of the 2017 rate notice, we ask that more work be done to maximize the corrective nature of the new model for high-need, full benefit dual eligibles, namely:

- 1) We strongly support the suggestion in your memo that additional research on the disease interaction terms is warranted. Specifically, we believe that the interaction of serious mental illnesses and chronic medical conditions should be thoroughly examined. We request continued transparency about this research and the opportunity to participate in a dialogue about it.
- 2) We also request clarification about how CMS will account for retroactive changes in Medicaid enrollment status in the proposed payment approach. We recommend that a process be put in place to reimburse plans for retroactive changes to Medicaid enrollment status.

Finally, while we support CMS' proposed revisions to the HCC model fully and without reservation and urge you to implement them without delay, there continue to be additional changes that could be made to the model to improve the predictive accuracy of the model for high-cost, high-need dual eligibles, including:

- Adding diagnoses for more mental health conditions and dementia, and restoring diagnoses for chronic kidney disease stages I-III to the model;
- Using a data set more representative of Medicare Advantage beneficiaries' needs and services - not only fee-for-service data -to build the model; and
- Finding ways to further address the challenges posed by social determinants of health that are not fully captured in one's dual status, such as homelessness. Our experience has taught us that the challenges of poverty influence how hard a member can be to serve and engage in their care.

As always, we greatly appreciate CMS' partnership in our work to provide fully integrated, high-quality, person-centered care to high-needs, dual eligible beneficiaries. We are greatly encouraged by CMS' recent efforts to really understand the true needs of dual eligible beneficiaries as evidenced by the

October 28th proposal and the revised terms for our One Care contract in Massachusetts. Thank you. I personally look forward to the opportunity to work together on these issues.

## **24. Community Catalyst**

Community Catalyst would like to express its support for CMS's proposal to adjust the way Medicare Advantage (MA) pays for full benefit Medicare-Medicaid beneficiaries ("dual eligible"). Community Catalyst is a national consumer advocacy organization dedicated to quality affordable health care for all. Since 1997 we have been working to build the consumer and community leadership required to transform the American health system. Our Voices for Better Health project has been particularly focused on bringing consumer voices forward to improve the way we pay for and deliver care for dually eligible beneficiaries.

We are committed to supporting the transformation of our health care system from one that rewards volume to one that emphasizes value and recognize that the current fee- for-service system too often fails the most vulnerable populations who are likely to be both low-income and to suffer from multiple chronic conditions. However as the system transitions to a variety of risk-based arrangements, it becomes critically important to appropriately adjust payments for poorer and sicker people or we risk undermining care for the very populations we are most trying to help. With that in mind, and in light of recent findings that the current approach underpays MA plans for full-benefit dual eligibles, we urge CMS to promptly implement proposed changes to the HCC to more accurately capture the cost experience of full-benefit dually eligible beneficiaries.

Although we believe that additional steps should be taken to more fully recognize the cost associated with the poorest and sickest beneficiaries and to address social determinants of health, we believe the proposed adjustment to be both a positive step forward. We also commend CMS for taking immediate action to apply the new policy to plans participating in the Medicare/Medicaid financial integration demonstration project. This step will help to protect the lives and well-being of vulnerable older adults and people with disabilities.

We very much appreciate the opportunity to comment on this proposal and to work with CMS in support of moving our health care system from one that emphasizes volume to one that is focused on value.

## **25. Community Health Group**

We are writing to comment on the proposed changes to the CMS-Hierarchical Condition Category ("HCC") Risk Adjustment Model for Payment Year 2017 as set forth in CMS' October 28, 2015 memorandum. We greatly appreciate the opportunity to comment on this important issue.

Community Health Group ("CHG") is a not-for-profit community-based safety net health plan that currently sponsors a "Cal MediConnect" Medicare-Medicaid Plan (MMP") as part of California's voluntary three-year dual-eligible demonstration project and formerly sponsored a Dual-Eligible Special Needs Plan ("D-SNP"). CHG's experiences with its MMP and D-SNP are entirely consistent with the findings of CMS that support the proposed changes to the CMS-HCC risk adjustment model. As CMS has indicated, the cost differences between full benefit duals and partial benefit duals as well as the cost differences between the disabled segment and the aged segment call for improving the accuracy of the CMS-HCC risk adjustment model. Such an improvement in the risk adjustment model is critically important in helping MMPs and D-SNPs become more sustainable and in allowing such plans to continue

to provide their enrollees (particularly their full benefit dual eligibles) with the services and care coordination that are unique to integrated MMPs and D-SNPs.

CHG is a member of the Association for Community Affiliated Plans ("ACAP") and concurs with ACAP's comments in its November 5, 2015 letter to CMS regarding the need to further evaluate the impact of utilization and demand for mental health services by the duals population. Due to the nature of these conditions, many dual eligible enrollees were not seeking or receiving necessary mental health services prior to enrolling in our duals programs. Enrollment in a managed care delivery model provides immediate assessment of the enrollees' mental health status and provides the enrollees with access to mental health services that often was not being addressed previously for the enrollees. Consequently, CHG believes that further evaluation and analysis in this area is needed to achieve predictability of additional mental health conditions and to reduce the under-prediction of the cost of the full-benefit dual eligible enrollees served by CHG.

## **26. Community Health Plan of Washington (CHPW)**

Community Health Plan of Washington (CHPW) greatly appreciates this opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) in response to its Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017. It is helpful for organizations such as CHPW to review and comment on proposed changes such as this before the Advance Notice is published.

CHPW is the only not-for-profit safety net health insurance plan in Washington State. Founded in 1992 by the state's federally qualified health centers, CHPW is a mission driven organization that strives to provide comprehensive managed care services to its 315,000 members. CHPW's target population is comprised of members who are typically older, often disabled, with multiple co-morbidities, including cancer, congestive heart failure, hypertension, obesity, dementia, and diabetes. To better serve our members, CHPW currently offers a Dual-Eligible Special Needs Plan (D-SNP) with more than 6,700 full-benefit members.

### **CMS Confirms CHPW's Position that Risk-Adjustment Under-Predicts for Full Duals.**

On October 28, CMS confirmed what CHPW and other safety net health plans have been asserting—that the Medicare Advantage (MA) risk-adjustment system under-predicts the cost of full-benefit dual eligible enrollees. Improving the accuracy of Medicare risk-adjustment for full-benefit dual eligible enrollees will help D-SNPs become more sustainable.

Ultimately, D-SNP sustainability is a consumer issue. If D-SNPs withdraw from the Medicare program due to inadequate payments, full-benefit dual eligible enrollees may experience the following:

- Losing access to services and care coordination that are only available through integrated D-SNPs;
- Disrupting their continuity of care; and
- Having to navigate Medicare and Medicaid (including long-term care and behavioral health) on their own.

## 27. Community Plans

The Association for Community Affiliated Plans (ACAP) greatly appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) in response to CMS' Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017. ACAP is an association of 61 not-for-profit, community-based Safety Net Health Plans located in 24 states. Our member plans provide coverage to over 15 million individuals enrolled in Medicaid, Children's Health Insurance Program (CHIP) and Medicare. Nineteen of our plans are Dual-Eligible Special Needs Plans (D-SNPs), fourteen of our plans are managed long-term care plans, and fifteen of our plans are Medicare-Medicaid Plans (MMPs) in the Financial Alignment Demonstration. Collectively, ACAP's MMPs account for close to 30 percent of all enrollments in the Financial Alignment Demonstration.

In the October 28th memo, CMS confirmed what ACAP has long been saying, that the Medicare Advantage (MA) risk-adjustment system under-predicts the costs of full-benefit dual eligibles. CMS also confirmed ACAP's D-SNP and MMP members' experiences that there are cost differences between full-benefit and partial-benefit duals, and between disabled and aged individuals. Improving the accuracy of Medicare risk-adjustment for full-benefit dual eligibles will help D-SNPs and MMPs become more sustainable.

Ultimately, D-SNP and MMP sustainability is a consumer issue. If D-SNPs or MMPs withdraw from the Medicare program due to payment inadequacy, full-benefit dual eligibles can experience a disruption in their continuity of care; they can lose access to the services and care coordination that are only available to them through integrated D-SNPs and MMPs; and they may have to navigate Medicare and Medicaid (including long-term care and behavioral health) on their own.

Given the importance of D-SNP and MMP sustainability to full-benefit dual eligibles, ACAP thanks CMS for evaluating and proposing ways to improve risk-adjustment for full-benefit duals. In addition, ACAP appreciates the analytic rigor of CMS' analysis and the agency's transparency in sharing the results, particularly the predictive ratios.

**ACAP welcomes and supports CMS' proposal to improve the accuracy of risk-adjustment for full-benefit dual eligibles.** We believe that CMS' proposal will improve the accuracy of the risk-adjustment model for full-benefit duals. This, in turn, will improve the sustainability of the D-SNPs and MMPs that enroll these individuals. **ACAP asks CMS to implement the proposed changes to the risk-adjustment model for MA plans, including D-SNPs, in 2017. We also ask CMS to implement the proposed changes for MMPs in 2016.** Moreover, the risk-adjustment model's under-prediction of full-benefit dual eligibles has resulted in under-payments to plans for these beneficiaries. We ask CMS to make retrospective payment adjustments for MMPs and D-SNPs to reimburse plans for these under-payments for their full-benefit dual-eligible enrollees.

We also encourage CMS to continue its analysis of refinements to the institutional model and the new enrollee model. We look forward to seeing the results of those analyses. Further, we ask for more information on the disease interaction terms that CMS is considering should differ by model segment. Finally, as CMS noted in the October 28<sup>th</sup> memo, the proposed changes do not fully eliminate the under-prediction for disabled dual-eligible individuals. We suspect the lack of mental health HCCs in the model may explain some of this continued under-prediction. ACAP D-SNPs and MMPs have found a high (30 to 44 percent) prevalence of mental health conditions among their full-benefit dual eligible enrollees. However, there are currently no HCC categories for depression, anxiety, or many other mental health conditions (e.g., PTSD and personality disorders). Accordingly, we ask CMS to re-evaluate the model to assess the predictability of additional mental health conditions, such as depression and anxiety, on dual

eligibles' costs and to add more mental health HCCs to the risk-adjustment model to further improve the model's accuracy.

## **28. Congresswoman Gwen Moore and Congressman Mark Pocan**

Thank you for the opportunity to comment on your October 28, 2015 memo, "Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017" (Memo).

We appreciate your attention to the difference in costs for treating members of dual-eligible populations, and believe you have proposed a workable solution to more accurately predict costs for insurers.

Dividing the model into 6 distinct community cells illustrates the differences in costs for the dual-eligible populations. As demonstrated in Table 4 of the Memo, the 2014 model has a predictive quotation of .892 for the full benefit dual-eligible aged population. As a practical matter that means that these recipients are being underfunded by 10.8%. Similarly, the full benefit dual disabled population is modeled at .947 meaning it has been underfunded by 5.3%.

As your model demonstrates, full benefit, both aged and disabled dual-eligible populations, require greater resources for care because of their limited economic means and critical need for effective coordinated medical care. Due to these individuals' extensive medical needs, their care is more costly than it is for non-dual or partial benefits dual-eligible people. The newly proposed predictive cost model will effectively demonstrate these differences in cost of care and help ensure these individuals receive the high-quality care they deserve. Additionally, suggested revisions to the model that allow for rates based on the payment year recognize the realities of current costs and eliminate existing lags in data.

While we must ensure that different dual-eligible populations receive appropriate and high quality care, it is reassuring that the data model CMS has developed verifies the need to adjust the rates for entities that focus on serving the full benefit dual-eligible population specifically. It is our hope that CMS will finalize its work on the new model and implement it as soon as possible.

## **29. DaVita HealthCare Partners Inc.**

DaVita is pleased to offer comments on the Centers for Medicare & Medicaid Services' (CMS/Agency) proposal to establish separate community segments for dual eligible, partial-dual, and non-dual beneficiaries under the CMS-Hierarchical Condition Category (HCC) risk adjustment model (model) for the 2017 payment year. As the nation's largest operator of medical groups and physician networks, we care for 959,000 health plan members, including 348,000 beneficiaries enrolled in Medicare Advantage (MA). We also operate and provide administrative services at over 2,000 outpatient dialysis centers, serving nearly 174,000 patients with End Stage Renal Disease (ESRD).

For more than 20 years, DaVita has been a leader in offering integrated care and developing innovative delivery strategies with the goals of improving quality and outcomes. We have significant experience in serving very frail Medicare beneficiaries, including dual eligible beneficiaries, and know first-hand that a holistic care approach is important in helping them maintain their health.

DaVita strongly supports efforts to improve the model's accuracy and commends CMS for working to address concerns about the model's predictive ability with respect to dual eligible beneficiaries. We also appreciate that CMS has made its initial analysis available prior to issuing the 2017 Advance Notice and has afforded stakeholders the opportunity to conduct preliminary assessments of the proposal. As the Agency continues to develop its 2017 payment year policies, we offer the following comments.

### **I. Release Additional Information As Soon As Possible and Afford Sufficient Opportunity to Assess Proposal**

DaVita is grateful that CMS released its initial analysis and believes it is a strong step toward promoting greater transparency, which is crucial to ensuring a more stable MA payment environment. We have conducted a preliminary review of the proposal and look forward to receiving additional information, including the model coefficients, necessary to conduct more in-depth analyses. We understand that CMS is continuing its own modeling and at this point, plans to release the coefficients as part of the 2017 Advance Notice issued in February 2016. We recognize the effort that goes into developing the Advance Notice, and the timing challenges that the Agency faces in conducting its modeling work. Should the Agency complete its modeling work sooner, we respectfully encourage it to release the coefficients prior to the 2017 Advance Notice. Earlier release of this information would give MA plans and providers additional time to better understand the proposal's impact at a program, plan, provider, and patient subpopulation level.

We also want to offer for consideration that a formal rulemaking process may be a more appropriate avenue for the development, consideration, and implementation of significant changes to the model. DaVita offers that recommendation in the spirit of promoting greater transparency and providing stakeholders sufficient opportunity to review the proposal and supporting evidence for a proposed change.

### **II. Consider the Collective Impact of Recent Changes to the CMS-HCC Model**

In recent years, CMS has announced and fully implemented the 2014 clinical revision, which among other changes, eliminated certain chronic kidney disease (CKD) condition categories due to concern about over-coding. The Agency also began using encounter data and risk adjustment processing system (RAPS) data to calculate blended risk scores. With respect to the 2014 clinical revision, DaVita agrees that CMS must address over-coding. However, we share the Medicare Payment Advisory Commission's (MedPAC) view that the coding intensity adjuster, not the risk adjustment model, is the appropriate mechanism to accomplish that objective. Regarding encounter data, we respectfully call on CMS to conduct and release statistical analyses to validate the data's accuracy and completeness. Until such analyses are completed, we believe that it is premature for CMS to move forward in using encounter data to calculate risk scores.

We raise these issues to illustrate that the proposal to create separate community segments for dual eligible, partial-dual, and non-dual beneficiaries comes at a time when MA plans and providers have been working to operationalize other significant modifications to the model. By CMS' own estimate, implementing the 2014 clinical revision will reduce 2016 MA payments by 1.7 percent, which is in addition to the \$18 billion in statutory reductions estimated by the Congressional Budget Office (CBO). Along with these payment impacts, DaVita encourages the Agency to consider that the proposal, especially the fact that beneficiaries could change segments throughout the year, will add to the model's complexity. We also respectfully request that the Agency consider possible interactions between recent changes, particularly the elimination of certain CKD condition categories from the 2014 clinical revision and the proposed separate community segments.

### **III. Ensure Payment Adequacy for All Beneficiaries with Complex Health Care Needs**

We again want to applaud CMS for its effort to respond to concerns about the model's predictive ability for dual eligible beneficiaries. As you know well, dual eligible beneficiaries are among the frailest and most vulnerable of all beneficiaries. These beneficiaries often have two or more chronic conditions, see

numerous providers, and take multiple prescription medicines each month. In addition, they face challenges, such as lack of transportation that can undermine their ability to get the care they need. Of all beneficiaries, dual eligibles are among those who stand to benefit the most from MA plans' delivery of integrated care, sophisticated care management programs, and additional benefits and support services.

DaVita has made substantial investments to develop and maintain the infrastructure necessary to serve all of our patients with complex health care needs, not just dual eligible beneficiaries. In addition to taking a multi-disciplinary care-team approach, we work to co-locate services and providers to make it easier for patients with multiple chronic conditions to access care and adhere to recommended treatment regimens.

We also have enhanced our information technology systems to promote better provider communication and to support our efforts to coordinate care. Our strong performance on clinical measures – consistent 4 and 5 ratings – shows that these investments are making a difference.

We wholeheartedly agree that MA plans must receive appropriate payments to ensure that dual eligible patients receive high-quality care, and that MA remains a strong coverage option for them. We understand that the Agency's initial analysis indicates that the separate segments address over-prediction and under-prediction issues among the various beneficiary groups, which is an incredibly important outcome. As the Agency moves forward, we encourage it to keep in mind that many non-dual beneficiaries also have complex health care needs and higher health care spending. We ask that the Agency work to ensure that the model results in adequate payments for these beneficiaries as well.

Again, DaVita is grateful to CMS for soliciting feedback on the proposal and looks forward to receiving additional analyses to better understand its impact.

### **30. Dynamic Healthcare Systems**

Thank you for the opportunity to comment on the proposed 2017 risk adjustment model changes to split the Community segment into 6 distinct populations.

**We would like to suggest these segments be identified using new RAF Type Codes and reported on the MMR in the current RAF Type Code field.** We believe this would present the least disruptive implementation from a systems perspective.

For example, the RAF Type for "C" Community would be broken out into RAF Types like

CA – Community: Full benefit dual aged

CB – Community: Full benefit dual disabled

CC – Community: Partial benefit dual aged

CD – Community: Partial benefit dual disabled

CE – Community: Non dual aged

CF – Community: Non dual disabled



## 31. Element Care

This constitutes the response of Element Care, Inc. (hereinafter "Element Care") to CMS' request for comment on the proposed changes to the HCC risk adjustment methodology.

### Background

Element Care is a Program of All-Inclusive Care for the Elderly that has operated in Lynn, Massachusetts for more than twenty years. We serve 961 individuals with significant complex chronic conditions and functional or cognitive impairment. All of our participants meet the state's definition of requiring a nursing home level-of-care. Approximately 466 of our enrollees have dementia.

We appreciate CMS' consideration of the following comments and recommendations:

### Comments

1) Element Care believes that developing risk factors for six distinct subpopulations of Medicare beneficiaries to acknowledge the impact of Medicaid eligibility status, along with institutional vs. community residence, will improve the accuracy of the risk adjustment system. Element Care supports the use of the subpopulations' distinct risk factors for establishing payments to PACE organizations. Element Care notes that approximately 92% of our enrollees are fully dual-eligible for Medicare and Medicaid.

2) In addition to calculating risk factors for the six distinct subpopulations of Medicare beneficiaries, CMS requests comments on changing the current PACE HCC model (HCC v. 21) to the 2014 model being phased in for MA plans (the "2014 model"). Element Care, as we have stated previously in response to CMS' 2013 advance notice of payment when it initially proposed the 2014 model, strongly recommends retaining the current PACE HCC model (HCC v.21) for PACE organizations. Shifting PACE to the 2014 model will reduce the performance of the risk adjustment model for PACE enrollees relative to the model that is currently in place.

The Evaluation of the CMS-HCC Risk Adjustment Model completed for CMS by RTI and released in March, 2011 assessed the predictive ratio of the CMS-HCC risk adjustment model v. 21 relative to an earlier version, v.1 2. The evaluation found that v.21 accurately predicts costs for Medicare beneficiaries and, in particular, significantly improved model performance over v.1 2 for beneficiaries with dementia.

Nearly 466 of all Element Care enrollees have dementia, as of August, 2015. The HCCs (51 and 52) for beneficiaries with dementia that are included in v. 21 and are related

to its improved predictive value in comparison to v. 12 are not in the 2014 HCC model. Because of the significance of dementia in the PACE enrollee population, we provide detailed comments on this condition and the impact of its removal from the HCC risk adjustment model below.

Further reducing the 2014 HCC model's accuracy when applied to PACE is its lack of HCCs that support the identification of interactions between early stages of kidney disease and congestive heart failure. Approximately 203 Element Care enrollees have a diagnosis of CHF, and of 447 Element Care enrollees are diagnosed with an early stage kidney disease (HCC 138, 139, 140 or 141). We have estimated that the 2014 HCC model would significantly reduce the average HCC score for Element Care beneficiaries with congestive heart failure and early stage kidney disease.

In combination, the 2014 HCC risk adjustment model results in a significant degradation of the CMS-HCC risk adjustment model's predictive value for the large majority of PACE enrollees.

3) The CMS-HCC risk adjustment model for PACE enrollees needs to include dementia.

Because of the significance of dementia for the cost and care of Element Care participants, the CMS-HCC risk adjustment model for PACE needs to include HCCs for dementia diagnoses. As noted earlier, approximately 466 Element Care participants are diagnosed with dementia, as indicated by the percent triggering either HCC51 or HCC52 for dementia in the CMS-HCC risk adjustment model currently applied to PACE (v.21). Removal of dementia related HCCs from the risk adjustment model significantly reduces the predictive ratio of the model for these PACE enrollees and, as a result, will undermine the financial sustainability of PACE programs.

Risk adjustment without HCCs for dementia results in substantial under prediction of the costs of care for enrollees with dementia, who comprise a large proportion of PACE organizations' total enrollment.

Referring to the Evaluation of the CMS-HCC Risk Adjustment Model that CMS released in March 2011, RTI compared predictive ratios for HCC chronic disease groups and concluded that v.21 of the CMS-HCC model was far superior to v.12 in predicting costs for beneficiaries with dementia. For beneficiaries with dementia, v.21 (with HCCs for dementia) of the model achieved a predictive ratio of 1.000 compared to 0.858 for v.12, which like the 2014 model used for MA plans lacks HCCs for dementia. This indicates that predicted costs for beneficiaries with dementia under v.12 are essentially 14% lower than actual costs. Based on historical diagnostic data, NPA's comparison of PACE organizations' mean HCC scores for PACE enrollees with dementia in the v21 model vs. the 2014 model used for MA plans indicates that the 2014 model generates mean HCC scores that are, on average, 21 % lower than v.21. We are deeply concerned that exclusion of dementia HCCs in the 2014 model leads to substantial underpayment for PACE enrollees with dementia. These individuals account for almost half of all PACE enrollees.

Failure to recognize dementia related costs is not consistent with CMS efforts to serve more people needing long-term services and supports through health plan options.

As CMS and states seek to enroll more people needing long-term services and supports in managed care options, the impact of under predicting costs associated with dementia will be broader than PACE. While for most Medicare Advantage plans the current prevalence of dementia is low, resulting in a minimal financial loss associated with the removal of dementia as a risk factor, the impact on PACE and other emerging options for people who need long-term services and supports, a large proportion of whom will have dementia, will be much greater.

4) Retaining the current PACE HCC model (v. 21) will reflect the costs of preventing early stage pressure ulcers.

A shift to the 2014 model would eliminate HCCs for pressure ulcers categorized as stage 1 or 2. Without these HCCs, the risk adjustment model would not take into consideration the care planning and treatment required in order to prevent these ulcers from escalating to a stage 3 or 4 ulcer. In the frail population served by PACE, individuals' compromised skin condition along with coexisting medical conditions such as diabetes and peripheral vascular disease often lead to the development of pressure ulcers. The early interventions PACE organizations provide avoid lower stage ulcers from progressing to stage 3 or 4 ulcers. If not prevented, these higher stage ulcers can require high cost procedures, hospitalizations and in some cases may lead to death. The HCC model for PACE should recognize, and incentivize, the investment in prevention made in caring for people with stage 1 and 2 ulcers.

## **Recommendations**

### **1. Retain the current v.21 of the CMS-HCC risk adjustment model for PACE**

Element Care strongly recommends that CMS retain the current v. 21 CMS-HCC risk adjustment model used for PACE payment. This HCC model recognizes the importance of dementia in predicting Medicare costs. In addition, this model appropriately reflects the costs of care for PACE participants with early stage pressure ulcers and early stage kidney disease that is comorbid with congestive heart failure. The combination of PACE county payment rates, the current v. 21 CMS-HCC risk adjustment model and frailty adjustment generates appropriate payment for our high cost population of Medicare beneficiaries.

This assessment is based in part on an analysis, previously shared with CMS by the National PACE Association, undertaken in response to CMS' implementation of the frailty adjustment model applied to PACE beginning in 2008. The study identified a PACE-like population from among respondents to the National Long Term Care Survey (NLTC) and compares their observed costs in FFS to the costs predicted by the v. 12 CMS-HCC risk adjustment model and revised frailty adjustment model. The study concluded their payments were substantially under predicted. A significant proportion of this under prediction was addressed by implementation of the v. 21 model in CY2012 and further addressed by implementation of the recalibrated frailty adjustment model in CY2013. Applying the MA 2014 model to PACE will undo the improvements in the risk adjustment methodology for PACE that have been achieved to date.

### **2. Apply distinct risk factors for the subpopulations of Medicare beneficiaries described in the request for comment to the calculation of payments for PACE organizations.**

We concur with CMS that dual-eligible status is a strong determinant of costs to the Medicare program. Establishing distinct risk factors for populations based on this eligibility status, along with institutional vs. community residence status, will improve the accuracy of the payment methodology for PACE.

In addition to the improved performance relative to the MA 2014 CMS-HCC risk adjustment model, retaining the v. 21 model offers the benefit of payment stability for PACE organizations. As comparatively small, not for profit organizations, PACE programs are particularly compromised in their ability to make financial commitments regarding developing and operating PACE by stark annual changes in Medicare's payment methodology.

## **32. EmblemHealth**

We appreciate CMS's efforts to provide advance information and transparency into the approach for changes to the 2017 risk adjustment model. EmblemHealth does not have any concerns with the basic approach to using a member's dual status in the risk adjustment model in order to improve the accuracy of the model in predicting costs. However, we need additional information in order to model the impact of these changes, specifically:

There is no mention of revenue neutrality and our plan is interested in the net impact of the model in aggregate.

- There are no specific HCC payment coefficients for the six proposed categories of community rated members; it is not possible to model the financial impact of these proposed changes without this information.

- We question the ability of plans to complete analysis of the financial impact within the confines of the comment period to the 45 day notice and request further detailed information regarding the model in advance of the 45 day notice.
- There is minimal information provided on the specific coefficients associated with the six proposed categories associated with the demographic factor in the HCC model. We are concerned regarding the loss of the Medicaid add in factor and whether the new demographic factors will achieve the financial results equivalent to the Medicaid add in payment factor.

Additionally, we are interested in accelerating the use of Managed Care specific encounter data (RAPs and EDS) in order to recalibrate the HCC model.

### **33. FirstCare Health Plans**

FirstCare Health Plans is a regional plan based in Texas. We are owned by two Texas hospitals Covenant Health and Hendrick Health System. Our lines of business include HMO, PPO, Medicare Advantage, Medicaid and CHIP products. We serve approximately 3,200 Medicare Advantage members in 25 counties for CY 2016. FirstCare also hosts an all-dual SNP serving both partial and full duals, which represents between 35% - 40% of its total MA population.

FirstCare Health Plans is pleased to respond to the Centers for Medicare & Medicaid Services' October 28, 2015 Memo on Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017 (HCC Risk Adjustment Model). FirstCare Health Plans thanks CMS for their thoughtful consideration in improving health plan regulations.

As a health plan that serves Medicare beneficiaries, we are committed to the most accurate care and payment for our beneficiaries. Specifically, as a plan that serves the partial duals, we have some questions and concerns with the proposed changes to the HCC Risk Adjustment Model. Our questions and concerns are outlined below:

#### **A. Varying State Eligibility Processes.**

CMS states in its Memo that it will use Medicaid eligibility data provided by each state for placement in the corresponding risk model. FirstCare Health Plans is unsure how CMS will account for the varying state eligibility processes. For example, many plans offer a grace period for dual eligible beneficiaries to re-apply if Medicaid eligibility is terminated. As such, the plan will keep those beneficiaries in a special needs plan during the application process. Or, conversely, some states are slow to provide information to plans. Additionally, beneficiaries are able to appeal the Medicaid decision, or simply re-apply. We also wonder if the Medicare Advantage plans' records might conflict with the corresponding CMS risk adjustment model placement, and if the plans will have an appeals process.

#### **B. Changes in Dual Status.**

FirstCare Health Plans believes that costs should not change much with changes in dual status. We are unclear how CMS analyzed and contrasted the predictive ratios for beneficiaries moving between dual status and those that have the same status over the year. FirstCare Health Plans is concerned that there may be an issue with the model account for movement between partial and full status throughout a plan year.

Many Medicare beneficiaries with partial Medicaid need to apply each year to keep Medicaid/Medicare Savers Program benefits. The needs of the member don't vary in cost because the beneficiary needs to

re-apply or has simply changed income. Also, many states have a lag between when social security provides the cost of living increase and the state Medicaid program re-assesses income levels for varying Medicaid programs. This is not simply a matter of timing, but in the scenario provided by CMS this member would have two varying risk scores, one derived from the partial dual model and one derived from the full dual model.

**C. Unrealistic Time for Health Plans to Properly Implement.**

CMS states in its Memo that it may not release the coefficients until the forty-five day notice is given. We believe this forty-five day notice is too short. Plans need time to understand the implications of these model changes, to plan for benefits and services, and consider how they will need to rethink administrative expenses. For some plans, this is not viable. Simply put, will the changes be too drastic, and will plans be unable to serve certain Medicare subpopulations, such as partial duals? Connected with the unrealistic timeframe for implementation, we are also concerned that CMS is establishing their predictive ratios on the fee-for-service population, which may look very different than the experience of the MAOs.

**D. CMS Does Not Use Their Traditional Phase-In Approach.**

CMS should consider a phased in approach. This is evidenced by historical regulatory policy implementation, such as the Affordable Care Act's county benchmark rating setting (phased in over 6 years), blending of V12 and V22 HCC risk models (phased in over 3 years), and using encounter and RAPs submission data for risk score generation (year 1 is 2016 with 90% RAPS/10% Encounter data, phasing period to be determined). Having an immediate implementation of this revised model does not give plans an opportunity to prepare for these changes over time.

**E. Undue Burden.**

The proposed modeling does not account for the significant administrative burden placed on plans to administer coordination of services between Medicare and Medicaid, to provide care management and care navigation programs, and perform quality improvement initiatives. Much of this burden is documented within the non-benefit expenses submitted with each plan bid, regardless of dual status. The burden is not reduced if a beneficiary is a partial dual. So, a reduction in payment for partial duals could unfairly penalize a plan. CMS could consider another type of co-efficient for all dual types, including the partials, to help shoulder the administrative burden of plans who have all – dual SNP plans.

**F. Needed Assessment of the Predictability of Additional Mental Health Conditions.**

The proposed changes do not fully eliminate the under-prediction for disabled dual-eligible individuals. The lack of mental health HCCs in the proposed model may explain some of this continued under-prediction. D-SNPs and MMPs have found a high (30 to 44 percent) prevalence of mental health conditions among their full-benefit dual eligible enrollees. However, there are currently no HCC categories for depression, anxiety, or many other mental health conditions (e.g., PTSD and personality disorders). Accordingly, we request CMS to re-evaluate the proposed model to assess the predictability of additional mental health conditions, such as depression and anxiety, on dual eligibles' costs and to add more mental health HCCs to the risk-adjustment model to further improve the model's accuracy.

**G. Other Points.**

1. We believe that CMS has not provided the coefficients for the six new model segments so plans cannot fully evaluate the impacts.

2. As a whole, the proposal will likely impact funding to the MA program because the model is calibrated based on the fee-for-service population, but the MA population has fewer duals than FFS.
3. On the issue of complexity, part of the proposal would move to a concurrent determination of Medicaid eligibility, which can change month-to-month, has a significant amount of retroactivity. This has an impact on our ability to accurately report the financials.

### **Conclusion**

FirstCare Health Plans appreciates the opportunity to comment on the important policy proposals crafted by CMS.

## **34. Franciscan Missionaries of Our Lady Health System**

This constitutes the response of Franciscan PACE (dba PACE Baton Rouge and PACE Lafayette) to CMS' request for comment on the proposed changes to the HCC risk adjustment methodology.

### **Background**

Franciscan PACE is a Program of All-Inclusive Care for the Elderly that has operated in Baton Rouge, LA for 7 years and Lafayette, LA for 5 months. We serve 166 individuals with significant complex chronic conditions and functional or cognitive impairment. All of our participants meet the state's definition of requiring a nursing home level-of-care. Approximately 92 of our enrollees have dementia.

We appreciate CMS' consideration of the following comments and recommendations: **Comments:**

- 1) Franciscan PACE believes that developing risk factors for six distinct subpopulations of Medicare beneficiaries to acknowledge the impact of Medicaid eligibility status, along with institutional vs. community residence, will improve the accuracy of the risk adjustment system. Franciscan PACE supports the use of the subpopulations' distinct risk factors for establishing payments to PACE organizations. Franciscan PACE notes that approximately 96% of our enrollees are fully dual-eligible for Medicare and Medicaid.
- 2) In addition to calculating risk factors for the six distinct subpopulations of Medicare beneficiaries, CMS requests comments on changing the current PACE HCC model (HCC v. 21) to the 2014 model being phased in for MA plans (the "2014 model"). Franciscan PACE, as we have stated previously in response to CMS' 2013 advance notice of payment when it initially proposed the 2014 model, **strongly recommends retaining the current PACE HCC model (HCC v.21) for PACE organizations.** Shifting PACE to the 2014 model will reduce the performance of the risk adjustment model for PACE enrollees relative to the model that is currently in place. The Evaluation of the CMS-HCC Risk Adjustment Model completed for CMS by RTI and released in March, 2011 assessed the predictive ratio of the CMS-HCC risk adjustment model v.21 relative to an earlier version, v.12. The evaluation found that v.21 accurately predicts costs for Medicare beneficiaries and, in particular, significantly improved model performance over v.12 for beneficiaries with dementia. Nearly 56% of all Franciscan PACE enrollees have dementia, as of August, 2015. The HCCs (51 and 52) for beneficiaries with dementia that are included in v.21 and are related to its improved predictive value in comparison to v.12 are not in the 2014 HCC model. Because of the significance of dementia in the PACE enrollee population, we provide detailed comments on this condition and the impact of its removal from the HCC risk adjustment model below.

Further reducing the 2014 HCC model's accuracy when applied to PACE is its lack of HCCs that support the identification of interactions between early stages of kidney disease and congestive heart

failure. Approximately 39 (24%) of Franciscan PACE enrollees have a diagnosis of CHF, and of 19 (11%) are diagnosed with an early stage kidney disease (HCC 138, 139, 140 or 141). We have estimated that the 2014 HCC model would **reduce** the average HCC score for Franciscan PACE beneficiaries with congestive heart failure and early stage kidney disease by **22%**! In combination, the 2014 HCC risk adjustment model results in a significant degradation of the CMS-HCC risk adjustment model's predictive value for the large majority of PACE enrollees.

3) The CMS-HCC risk adjustment model for PACE enrollees **needs** to include dementia.

Because of the significance of dementia for the cost and care of Franciscan PACE participants, the CMS-HCC risk adjustment model for PACE needs to include HCCs for dementia diagnoses. As noted earlier, approximately 92 of Franciscan PACE participants are diagnosed with dementia, as indicated by the percent triggering either HCC51 or HCC52 for dementia in the CMS-HCC risk adjustment model currently applied to PACE (v.21). Removal of dementia related HCCs from the risk adjustment model significantly reduces the predictive ratio of the model for these PACE enrollees and, as a result, will undermine the financial sustainability of PACE programs. Risk adjustment without HCCs for dementia results in substantial under prediction of the costs of care for enrollees with dementia, who comprise a large proportion of PACE organizations' total enrollment. Referring to the Evaluation of the CMS-HCC Risk Adjustment Model that CMS released in March 2011, RTI compared predictive ratios for HCC chronic disease groups and concluded that v.21 of the CMS-HCC model was far superior to v.12 in predicting costs for beneficiaries with dementia. For beneficiaries with dementia, v .21 (with HCCs for dementia) of the model achieved a predictive ratio of 1.000 compared to 0.858 for v.12, which like the 2014 model used for MA plans lacks HCCs for dementia. This indicates that predicted costs for beneficiaries with dementia under v.12 are essentially 14% lower than actual costs. Based on historical diagnostic data, NPA's comparison of PACE organizations' mean HCC scores for PACE enrollees with dementia in the v21 model vs. the 2014 model used for MA plans indicates that the 2014 model generates mean HCC scores that are, on average, 21% lower than v.21 . **We are deeply concerned that exclusion of dementia HCCs in the 2014 model leads to substantial underpayment for PACE enrollees with dementia.**

These individuals account for almost half of all PACE enrollees. Failure to recognize dementia related costs is not consistent with CMS efforts to serve more people needing long-term services and supports through health plan options. As CMS and states seek to enroll more people needing long-term services and supports in managed care options, the impact of under predicting costs associated with dementia will be broader than PACE. While for most Medicare Advantage plans the current prevalence of dementia is low, resulting in a minimal financial loss associated with the removal of dementia as a risk factor, the impact on PACE and other emerging options for people who need long-term services and supports, a large proportion of whom will have dementia, will be much greater.

4) Retaining the current PACE HCC model (v. 21) will reflect the costs of preventing early stage pressure ulcers. A shift to the 2014 model would eliminate HCCs for pressure ulcers categorized as stage 1 or 2. Without these HCCs, the risk adjustment model would not take into consideration the care planning and treatment required in order to prevent these ulcers from escalating to a stage 3 or 4 ulcer. In the frail population served by PACE, individuals' compromised skin condition along with coexisting medical conditions such as diabetes and peripheral vascular disease often lead to the development of pressure ulcers. The early interventions PACE organizations provide, avoid lower stage ulcers from progressing to stage 3 or 4 ulcers. If not prevented, these higher stage ulcers can require high cost procedures, hospitalizations and in some cases may lead to death. **The HCC model**

for PACE should recognize, and incentivize, the investment in prevention made in caring for people with stage 1 and 2 ulcers.

**Recommendations:**

1. **Retain the current v.21 of the CMS-HCC risk adjustment model for PACE.** NPA strongly recommends that CMS retain the current v. 21 CMS-HCC risk adjustment model used for PACE payment. This HCC model recognizes the importance of dementia in predicting Medicare costs. In addition, this model appropriately reflects the costs of care for PACE participants with early stage pressure ulcers and early stage kidney disease that is comorbid with congestive heart failure. The combination of PACE county payment rates, the current v.21 CMS-HCC risk adjustment model and frailty adjustment generates appropriate payment for our high cost population of Medicare beneficiaries. This assessment is based in part on an analysis, previously shared with CMS by the National PACE Association, undertaken in response to CMS' implementation of the frailty adjustment model applied to PACE beginning in 2008. The study identified a PACE-like population from among respondents to the National Long Term Care Survey (NLTCS) and compares their observed costs in FFS to the costs predicted by the v.12 CMS-HCC risk adjustment model and revised frailty adjustment model. The study concluded their payments were substantially under predicted. A significant proportion of this under prediction was addressed by implementation of the v. 21 model in CY2012 and further addressed by implementation of the recalibrated frailty adjustment model in CY2013. Applying the MA 2014 model to PACE will undo the improvements in the risk adjustment methodology for PACE that have been achieved to date.
2. **Apply distinct risk factors for the subpopulations of Medicare beneficiaries described in the request for comment to the calculation of payments for PACE organizations.** We concur with CMS that dual-eligible status is a strong determinant of costs to the Medicare program. Establishing distinct risk factors for populations based on this eligibility status, along with institutional vs. community residence status, will improve the accuracy of the payment methodology for PACE. In addition to the improved performance relative to the MA 2014 CMS-HCC risk adjustment model, retaining the v.21 model offers the benefit of payment stability for PACE organizations. As comparatively small, not for profit organizations, PACE programs are particularly compromised in their ability to make financial commitments regarding developing and operating PACE by stark annual changes in Medicare's payment methodology.

## 35. Gateway Health

I would like to submit the following comment:

Can CMS provide a PY 2017 Beta HCC Model to the public to allow analysis and feedback as to whether the model accounts for the differences in reimbursement to the SNP populations?

This would allow Health Plans to validate whether the risk adjustment model would adequately predict costs for our CSNP population. We could then provide a member level analysis to show whether their regression models are accounting those unique markers that impact our populations. This would enable us to improve our planning during the bid process.



## 36. Geisinger Health Plan

1. Will the SAS models be provided with the 2017 advanced notice or earlier?
2. Since CMS noted they were calibrating the models based on FFS 2013-2014 data, will the diagnosis and HCC mapping be based off the 2014 model since it was mentioned that this component will not be changing?
3. Are revisions being made to the ESRD model?
4. Will there be any other adjustments being considered around the risk adjustment process for Payment Year 2017?
5. The CMS Agent Broker Compensation Report files show information specific to each beneficiaries duration, as well as their prior plan type. Could CMS consider performing a similar analysis of predictive ratios using these data elements to quantify the implicit subsidies that exist within the MA Coding Intensity factor? This factor is applied uniformly across all enrollees, independent of MA coding duration and prior plan type, which are both likely to be correlated with coding intensity.

## 37. Health Care For All (HCRA)

Health Care For All (HCFA) is the leading Massachusetts non-profit consumer health care advocacy organization. We work to create a health care system that provides comprehensive, affordable, accessible, and culturally competent care to everyone, especially the most vulnerable among us. We achieve this as leaders in public policy, advocacy, organizing, education and service to consumers in Massachusetts.

We are proud supporters of the Massachusetts One Care program for dual eligible beneficiaries with disabilities. HCFA works closely with One Care members and other advocates to promote improvements to the program. We serve on the Implementation Council convened by the state to advise the program, and have been sharing the lessons derived from One Care in the state's broader effort to redesign our Medicaid program to focus on rewarding value, patient engagement and accountable care. We also serve as the initial point of contact for the One Care Ombudsman program through our multi-lingual statewide HelpLine.

Health Care For All supports CMS' proposal to adjust Medicare Advantage, payments for full benefit, dually-eligible Medicare-Medicaid beneficiaries.

We know that the current fee-for-service system does not meet the needs of our most vulnerable populations who live with multiple chronic conditions and we are encouraged by the benefits inherent in alternative models.

However, payments under alternative risk-based systems must appropriately adjust payments to cover poorer and sicker members, or plans will not have the resources to fully provide the high- quality care for the very populations who need the most care.

Research has demonstrated that existing payment systems underpay plans caring for full-benefit dual eligible members. We request that CMS immediately implement the proposed change in payment adjustments to more accurately reflect the true costs of full-benefit dually eligible beneficiaries.

We appreciate this opportunity to support the vital One Care program. Massachusetts has been at the vanguard of national health reform efforts and we continue to move toward a health care payment system that emphasizes value-based accountable care. This model, and potentially healthier outcomes,

will only work with proper payment levels that appropriately reflect the health care needs of the population served. We hope CMS will consider our comments as it moves forward in this arena and thank you in advance for your consideration.

### **38. Health Care Service Corporation (HCSC)**

Health Care Service Corporation (HCSC) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the Proposed Changes to the CMS- HCC Risk Adjustment Model for Payment Year 2017 as announced in the HPMS Memo dated October 28, 2015.

HCSC is the largest customer-owned health insurance company in the United States. The company offers a wide variety of health and life insurance products and related services, through its operating divisions and subsidiaries including Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Montana, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas. HCSC employs more than 23,000 people and serves more than 15 million members. HCSC has established Medicare Advantage (MA) plans and Part D Prescription Drug (Part D) stand-alone plans in all five of the HCSC states.

#### **Comments**

In the proposal, CMS states that the agency has studied how well the CMS-HCC risk adjustment model predicts costs based on beneficiaries' dual eligible status in the payment year. CMS measured the predictive ratios (PR) for the beneficiaries based on dual status, aged/disabled status, and community/institutional status. CMS' findings show that the community segment of the 2014 model predicts fairly accurately for non-dual eligible beneficiaries (PR=1.015) and somewhat over predicts for partial benefit dual eligible beneficiaries (PR=1.092), while it somewhat under predicts for full benefit dual eligible beneficiaries (PR=0.914).

Based on these findings, CMS has focused model development efforts on the community segment of the CMS-HCC model. CMS is considering separate model segments for six subgroups of dual eligibles because the analysis indicates that these subgroups have distinct cost profiles. Those six segments are:

- Full benefit dual-aged;
- Full benefit dual-disabled;
- Partial benefit dual-aged;
- Partial benefit dual-disabled;
- Non-dual – aged; and
- Non-dual – disabled.

HCSC supports CMS' goal of making the risk adjustment model more accurate and we believe that these refinements generally are moving in the right direction to address discrepancies in payment among non-dual, partial dual, and full dual aged and disabled beneficiaries. However, it is difficult to determine the impact of the proposed changes, whether this is the best approach, and whether it could result in unintended consequences for beneficiaries.

HCSC recommends that CMS release additional information to permit MA organizations (MAOs) to analyze the impacts. For example, it would be helpful to have the HCC regression coefficients for each segment to determine the full impact of the proposed changes on the non-institutional community-based enrollees. This would enable MAOs to provide more useful feedback as well as an opportunity to

plan more effectively for the impacts. In addition, it would be informative to know which statistical tests CMS used and what the significance was (e.g., p-value). Further, we appreciate that CMS will release the relative factors of the revised model in the 2017 Advance Notice, and we believe this should enable further analysis of the impact of the proposal.

CMS states that aged and disabled status are mutually exclusive so that when beneficiaries who are entitled to Medicare based on disability reach age 65, they are categorized in the aged segment. While CMS includes an adjustment for disability for those individuals who are both dual and disabled, it is not clear that the adjustment is adequate, especially given the proposed changes to the model.

HCSC recommends that CMS evaluate the predictive accuracy of the proposed model for those beneficiaries who are both aged and disabled and release the results of the analysis for MAOs to evaluate the adequacy of projected costs.

CMS states that the agency is not conducting a clinical revision of the HCCs for the contemplated model revision. Further, CMS is exploring whether the disease interaction terms should differ by model segment.

HCSC encourages CMS to continue to look for ways to improve the model for the future. However, revising the HCCs or differing the disease interaction terms at the same time as implementing changes to the model would add further complexity and make it even more difficult to determine and plan for the impacts of the proposed changes. We also are concerned that adding too many variables to an analysis of the model will limit its predictive power and could create unintended consequences for beneficiaries. Consequently, we recommend continuing the research in this area, but delaying further changes until future years.

HCSC also specifically encourages CMS to include in the research an analysis of the impact of terminal conditions on the risk adjustment model. We believe plans incur significant costs for beneficiaries in the last six months of life that are not captured accurately in the model or in payments to plans. We recommend CMS review this issue and address it in future discussions of the risk model.

We appreciate the partnership we have with CMS in serving beneficiaries through Medicare Advantage and Part D programs. In addition, we especially appreciate CMS' efforts to improve the risk adjustment model to ensure beneficiaries are well-served by these programs.

## **39. Health Choice**

Thank you for the opportunity to provide comments related to the proposed changes to the CMS-HCC risk adjustment model for payment year 2017.

Health Choice Generations (Health Choice) is a URAC Accredited Dual Eligible Special Needs Plan (D-SNP) serving over 9,500 Arizona Medicare-Medicaid enrollees. Our D-SNP began serving members in January 2006 based on encouragement from the Arizona State Medicaid Agency, Arizona Health Care Cost Containment System (AHCCCS).

While Arizona is already a national leader in integration of care and coordination of benefits, especially for the dual eligible population, Health Choice continues to find innovative methods to meet the specialized needs of dual eligible members and the vision of AHCCCS and CMS.

Specifically, our plan recognizes that in addition to meeting the medical needs of our members, we must also address the social determinants that negatively impact health outcomes.

Health Choice, which solely serves dual eligible members, is challenged by the unique demographic and clinical characteristics of our population.

These characteristics include:

45% of our population live in a rural area;

20% of our population are non-English speaking;

50% are under the age of 65 with physical disabilities; and

20% of our members are using 10 or more maintenance medications.

Health Choice greatly appreciates CMS's acknowledgement that caring for dual populations, in particular the aged and disabled subgroups, have distinct cost profiles, relative to other Medicare Advantage populations. We applaud CMS's efforts to revise its risk adjustment model to better predict costs for beneficiaries based on their dual status and age/disabled status for PY 2017.

Adjusting the compensation model according to the higher costs associated with caring for beneficiaries with the greatest health disparities provides an equitable approach that:

Ensures that the services for which people are covered are adequately funded;

Provides financial alignment with the actual operational costs of serving the most vulnerable individuals;

Is consistent with the Congressional intent of the establishment of SNPs in 2006;

Diminishes the unintended consequences of applying a universal payment methodology to a program that is meant to support the managed coordination and provision of services not readily available in the fee-for-service environment; and

Allows for meaningful choice in the marketplace, in that it will financially enable more plans to continue to provide products for dual beneficiaries.

Thank you again for the opportunity to comment. We greatly appreciate your consideration of these comments.

## **40. Health Partners Plans**

Health Partners Plans would like to see CMS use Medicare Advantage data to calculate revised risk scores, as opposed to using the Fee-For-Service data.

## **41. Health Plan of San Mateo (HPSM)**

On behalf of the Health Plan of San Mateo (HPSM), I am writing to express our strong support for the proposed changes to the CMS HCC risk adjustment model as outlined in the October 28, 2015 memo titled "Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017" and in the November 12, 2015 memo titled "Medicare A/B Payment to Medicare- Medicaid Plans Participating in the Financial Alignment Initiative for Contract Year 2016."

HPSM is a local, community-based managed care plan serving the needs of more than 140,000 members of San Mateo County, CA. We have extensive experience servicing the unique needs of full benefit dual eligibles. Since 2006, we have operated a Special Needs Plan (DSNP) that targets only full benefit dual eligibles. We were also the first California Medicare-Medicaid Plan (MMP) to start the Financial Alignment Demonstration in April 2014. Approximately 10,000 full benefit dual eligibles are currently enrolled with us, representing nearly two-thirds of all full benefit dual eligibles in our service area.

We have long argued that the CMS HCC risk adjustment model does not adequately account for the higher costs and resources needed to serve full benefits duals compared to Medicare Advantage plans serving non-duals or partial duals. We support and are encouraged by CMS efforts to apply analytic rigor to this issue and for your willingness to be transparent with the outcomes of your analysis (such as sharing the predictive ratios) so that managed care plans, beneficiaries, providers and other stakeholders are better informed about the risk adjustment model and differences between full benefit duals and partial duals. We urge that CMS continue ongoing efforts to refine its HCC risk adjustment model and be transparent with any available data and analytic outcomes.

Implementation of the proposed changes to improve the accuracy of the HCC risk adjustment model and payment to MMPs must be done as soon as possible, as the sustainability of California's demonstration is dependent on adequate financing for participating managed care plans. We support the CMS proposal described in the Nov 12, 2015 memo to implement the risk adjustment change to MMP payments for the upcoming 2016 benefit year. However, we also urge CMS to implement these same changes retroactive to the beginning of California's demonstration – as 2014 and 2015 represent nearly half of the demonstration period. As CMS has acknowledged, the under-predication of full benefit duals in the current risk adjustment model has resulted in under-payments in 2014 and 2015 to MMPs. This correction would improve the sustainability of MMPs that serve exclusively full benefit duals.

Thank you for the opportunity to provide comments and share our local perspective.

## **42. Healthcare Leadership Council**

The Healthcare Leadership Council (HLC) appreciates the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services (CMS) Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017. We applaud CMS for recognizing that the current model under predicts the true cost associated with caring for beneficiaries with more complex health needs. It is critically important for the risk adjustment model to appropriately account for the impact of Medicare's sickest and poorest beneficiaries on health plans' risk scores and Star Ratings.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century health system that makes affordable, high-quality care accessible to all Americans. Members of HLC—hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, biotech firms, health product distributors, pharmacies, and information technology companies—advocate measures to increase the quality and efficiency of healthcare through a patient-centered approach.

Improving the accuracy of Medicare risk adjustment is vital to ensure that health plans are able to maintain stability and provide care to beneficiaries, even the most frail and those with high costs. HLC supports CMS' proposed updates to the current CMS- Hierarchical Condition Category (HCC) risk adjustment model as a promising first step. However, we recommend several changes to make the model workable and protect all beneficiaries. These include:

Providing additional transparency around risk adjustment model updates by incorporating a formal notice and 60-day comment process and releasing needed information that would enable stakeholders to assess the impact of the proposed changes. For example, more information is needed on the market segments proposed by CMS and how they would interact in order to facilitate robust analysis.

Continuing to refine the risk adjustment model to make it more accurate and appropriate overall.

Delaying implementation and phasing in changes to allow for clarification and adequate time to further assess the proposal, especially given the magnitude of the proposed changes and the operational implications of implementation.

HLC appreciates the opportunity to provide comments on the proposed changes to the CMS-HCC Risk Adjustment model and we look forward to working with you on refining policy solutions to further address this issue. We urge you to consider us a partner as CMS moves forward with its efforts.

## 43. Healthfirst

### Risk Adjustment and Coding Intensity in Medicare Advantage

*A. Proposed Changes to HCC Risk Adjustment Model.* We are, again, very appreciative of CMS's recently released proposal for changes in the CMS-HCC Risk Adjustment Model for payment year 2017.

Though we cannot model the exact impact of the proposed approach due to its use of fee-for-service data, we support and appreciate the proposed segmentation approach which recognizes the distinct cost profiles that exist across the spectrum of dual and aged/disabled statuses. **We recommend that CMS utilize the model that will most accurately predict cost across Medicare. Based on the analysis shared in the memo, the 6-segment approach would provide the most accurate prediction of cost. We encourage CMS not only to use the 6-segment model but to move directly to this revised model for the 2017 payment year without a phase-in.** This will offer an immediate course correction to risk score calculations that have heretofore inadvertently disadvantaged the program's neediest and most vulnerable populations.

We agree with the decision to exclude the Institutional segment of the population from these changes, but recommend that CMS continue to explore opportunities to better understand costs associated with new members. Applying the 6-segment approach to this cohort of members may yield similar findings and allow for further refinement to the risk adjustment model, driving greater accuracy in payment.

Finally, the complexity of administering month-to-month risk scores in a given payment year based on a member's dual and aged/disabled status is too complex. Plans have difficulty today reconciling these status codes on the enrollment files provided by CMS. To avoid the additional administrative complexity of applying several risk scores for a member across a given year, as well as to recognize that a change to a member's Medicaid status may not reflect an actual change to their needs but instead an inability to complete the complex administrative processes to maintain Medicaid status, **we recommend that CMS continue to use a single month of Medicaid eligibility as the status driver for the full payment year.**

*B. Across-the-board Coding Intensity Adjustment Cuts.* While we are grateful that the proposed HCC model changes will help improve the accuracy of risk scores, we are concerned that any improvement we see as a result of the model changes will be more than wiped out by the across-the-board application of the coding intensity adjustment (CIA).

In 2016, CMS will reduce MA risk scores by the statutory minimum of 5.41%. CMS applies the 5.41% reduction to all plans, regardless of their individual degrees of coding intensity. This across-the-board application of the coding intensity factor actually lowers our risk scores to below the fee-for-service equivalent because, apparently, our coding intensity is lower (perhaps significantly) than the average.

As a 2014 CMS study shows, the MA landscape is heterogeneous with different coding patterns across plans, and this across-the-board application is inherently inequitable. Plans with lower coding intensity are subsidizing those with higher coding intensity, the approach has locked in the early higher intensity

profile that these plans achieved prior to the CIA, and this inequity grows over time as the coding intensity factor grows.

For Healthfirst, which has a coding intensity that is only 1.5% higher than Fee-For-Service Medicare, the across-the-board application of the nationally observed coding intensity differential cuts our risk scores to significantly below the FFS equivalent.

**We ask CMS to implement a more segmented approach (e.g., quartiles of observed differences from FFS) to apply the coding intensity factor to account for coding differences among plans.**

This methodology change would be consistent with the segmented approach of CMS's proposed HCC risk model changes. It is also an alternative that MedPAC notes can (1) address the current inequity for plans that code less intensively as well as (2) remove incentives to increase coding intensity.

#### **44. HealthPartners, Inc.**

We appreciate the opportunity to comment on CMS' proposed changes to the HCC-Risk Adjustment model for PY2017. I am providing the below comments on behalf of HealthPartners, Inc.

##### **Proposed HCC Model Changes**

We support CMS' proposal to develop and implement a revised HCC model that includes separate model segments for various dual eligible populations for use in 2017 payment. We are in agreement with CMS that this approach has the potential to correct systemic under-prediction of costs for dual-eligible beneficiaries in the current HCC model. In addition, we support CMS' proposal to make minor updates to the institutional and new enrollee segments to distinguish between full and partial benefit duals, as we agree with CMS that this distinction is important in predicting and explaining costs.

However, we are concerned that the proposal will decrease payment for non-dual aged in geographic regions like Minnesota, where payment is already significantly lower than the rest of the country. There is no geographic factor to the proposal and we urge CMS to consider adding such a factor. Furthermore, there is uncertainty with the transition to ICD-10 and impact to risk scores. Plans may be hit twice with payment decreases.

##### **Timing of Release**

While we appreciate that CMS has announced this proposal well in advance of the 2017 bid season, we request that CMS release proposed HCC model weights before the Advance Notice in February so that plans have sufficient time to analyze the impact on their population and make appropriate comments to CMS. As the potential impact of this model change is substantial, we do not believe using the standard public comment timeline associated with the Advance Notice gives plans enough time to react to the change.

#### **45. Hopkins ElderPlus**

This constitutes the response of The Johns Hopkins Health System Corporation to CMS' request for comment on the proposed changes to the HCC risk adjustment methodology.

##### **Background**

The Johns Hopkins Health System Corporation has operated Hopkins ElderPlus, a Program of All-Inclusive Care for the Elderly since 1996. Hopkins ElderPlus operates in Baltimore, MD and serves up to 150 individuals with significant complex chronic conditions and functional or cognitive impairment. All of

our participants meet the state's definition of requiring a nursing home level-of-care. Approximately 47% of our enrollees have dementia.

We appreciate CMS' consideration of the following comments and recommendations:

### **Comments**

- 1) Hopkins ElderPlus believes that developing risk factors for six distinct subpopulations of Medicare beneficiaries to acknowledge the impact of Medicaid eligibility status, along with institutional vs. community residence, will improve the accuracy of the risk adjustment system. Hopkins ElderPlus supports the use of the subpopulations' distinct risk factors for establishing payments to PACE organizations. Hopkins ElderPlus notes that approximately 90% of our enrollees are fully dual-eligible for Medicare and Medicaid.
- 2) In addition to calculating risk factors for the six distinct subpopulations of Medicare beneficiaries, CMS requests comments on changing the current PACE HCC model (HCC v. 21) to the 2014 model being phased in for MA plans (the "2014 model"). Hopkins ElderPlus agrees with the response by the National PACE Association to CMS' 2013 advance notice of payment when it initially proposed the 2014 model, and strongly recommends retaining the current PACE HCC model (HCC v.21) for PACE organizations. Shifting PACE to the 2014 model will reduce the performance of the risk adjustment model for PACE enrollees relative to the model that is currently in place.

The Evaluation of the CMS-HCC Risk Adjustment Model completed for CMS by RTI and released in March, 2011 assessed the predictive ratio of the CMS-HCC risk adjustment model v. 21 relative to an earlier version, v.12. The evaluation found that v. 21 accurately predicts costs for Medicare beneficiaries and, in particular, significantly improved model performance over v.12 for beneficiaries with dementia.

Nearly 47% of all Hopkins ElderPlus enrollees have dementia, as of August, 2015. The HCCs (51 and 52) for beneficiaries with dementia that are included in v. 21 and are related to its improved predictive value in comparison to v. 12 are not in the 2014 HCC model. Because of the significance of dementia in the PACE enrollee population, we provide detailed comments on this condition and the impact of its removal from the HCC risk adjustment model below.

Further reducing the 2014 HCC model's accuracy when applied to PACE is its lack of HCCs that support the identification of interactions between early stages of kidney disease and congestive heart failure. Approximately 36% of Hopkins ElderPlus enrollees have a diagnosis of CHF, and of these 17% are diagnosed with an early stage kidney disease (HCC 138, 139, 140 or 141). We have estimated that the 2014 HCC model would reduce the average HCC score for Hopkins ElderPlus beneficiaries with congestive heart failure and early stage kidney disease by 22%.

In combination, the 2014 HCC risk adjustment model results in a significant degradation of the CMS-HCC risk adjustment model's predictive value for the large majority of PACE enrollees.

- 3) The CMS-HCC risk adjustment model for PACE enrollees needs to include dementia.

Because of the significance of dementia for the cost and care of Hopkins ElderPlus participants, the CMS-HCC risk adjustment model for PACE needs to include HCCs for dementia diagnoses. As noted earlier, approximately 47% of Hopkins ElderPlus participants are diagnosed with dementia, as indicated by the percent triggering either HCC51 or HCC52 for dementia in the CMS-HCC risk adjustment model currently applied to PACE (v.21). Removal of dementia related HCCs from the risk adjustment model significantly reduces the predictive ratio of the model for these PACE enrollees



and, as a result, will undermine the financial sustainability of PACE programs. Risk adjustment without HCCs for dementia results in substantial under prediction of the costs of care for enrollees with dementia, who comprise a large proportion of PACE organizations' total enrollment.

Referring to the Evaluation of the CMS-HCC Risk Adjustment Model that CMS released in March 2011, RTI compared predictive ratios for HCC chronic disease groups and concluded that v.21 of the CMS-HCC model was far superior to v.12 in predicting costs for beneficiaries with dementia. For beneficiaries with dementia, v.21 (with HCCs for dementia) of the model achieved a predictive ratio of 1.000 compared to 0.858 for v.12, which like the 2014 model used for MA plans lacks HCCs for dementia. This indicates that predicted costs for beneficiaries with dementia under v.12 are essentially 14% lower than actual costs. Based on historical diagnostic data, NPA's comparison of PACE organizations' mean HCC scores for PACE enrollees with dementia in the v21 model vs. the 2014 model used for MA plans indicates that the 2014 model generates mean HCC scores that are, on average, 21% lower than v.21. We are deeply concerned that exclusion of dementia HCCs in the 2014 model leads to substantial underpayment for PACE enrollees with dementia. These individuals account for almost half of all PACE enrollees. Failure to recognize dementia related costs is not consistent with CMS efforts to serve more people needing long-term services and supports through health plan options.

As CMS and states seek to enroll more people needing long-term services and supports in managed care options, the impact of under predicting costs associated with dementia will be broader than PACE. While for most Medicare Advantage plans the current prevalence of dementia is low, resulting in a minimal financial loss associated with the removal of dementia as a risk factor, the impact on PACE and other emerging options for people who need long-term services and supports, a large proportion of whom will have dementia, will be much greater.

- 4) Retaining the current PACE HCC model (v. 21) will reflect the costs of preventing early stage pressure ulcers.

A shift to the 2014 model would eliminate HCCs for pressure ulcers categorized as stage 1 or 2. Without these HCCs, the risk adjustment model would not take into consideration the care planning and treatment required in order to prevent these ulcers from escalating to a stage 3 or 4 ulcer. In the frail population served by PACE, individuals' compromised skin condition along with coexisting medical conditions such as diabetes and peripheral vascular disease often lead to the development of pressure ulcers. The early interventions PACE organizations provide avoids lower stage ulcers from progressing to stage 3 or 4 ulcers. If not prevented, these higher stage ulcers can require high cost procedures, hospitalizations and in some cases may lead to death. The HCC model for PACE should recognize, and incentivize, the investment in prevention made in caring for people with stage 1 and 2 ulcers.

## **Recommendations**

### **1. Retain the current v.21 of the CMS-HCC risk adjustment model for PACE**

Hopkins ElderPlus strongly recommends that CMS retain the current v.21 CMS-HCC risk adjustment model used for PACE payment. This HCC model recognizes the importance of dementia in predicting Medicare costs. In addition, this model appropriately reflects the costs of care for PACE participants with early stage pressure ulcers and early stage kidney disease that is comorbid with congestive heart failure. The combination of PACE county payment rates, the current v.21 CMS-HCC risk adjustment model and

frailty adjustment generates appropriate payment for our high cost population of Medicare beneficiaries.

This assessment is based in part on an analysis, previously shared with CMS by the National PACE Association, undertaken in response to CMS' implementation of the frailty adjustment model applied to PACE beginning in 2008. The study identified a PACE-like population from among respondents to the National Long Term Care Survey (NLTC) and compares their observed costs in FFS to the costs predicted by the v.12 CMS-HCC risk adjustment model and revised frailty adjustment model. The study concluded their payments were substantially under predicted. A significant proportion of this under prediction was addressed by implementation of the v.21 model in CY2012 and further addressed by implementation of the recalibrated frailty adjustment model in CY2013. Applying the MA 2014 model to PACE will undo the improvements in the risk adjustment methodology for PACE that have been achieved to date.

**2. Apply distinct risk factors for the subpopulations of Medicare beneficiaries described in the request for comment to the calculation of payments for PACE organizations.**

We concur with CMS that dual-eligible status is a strong determinant of costs to the Medicare program. Establishing distinct risk factors for populations based on this eligibility status, along with institutional vs. community residence status, will improve the accuracy of the payment methodology for PACE.

In addition to the improved performance relative to the MA 2014 CMS-HCC risk adjustment model, retaining the v. 21 model offers the benefit of payment stability for PACE organizations. As comparatively small, not for profit organizations, PACE programs are particularly compromised in their ability to make financial commitments regarding developing and operating PACE by stark annual changes in Medicare's payment methodology.

## **46. Humana Inc.**

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. Humana serves approximately 14 million total medical members receiving medical services across the country. As one of the nation's top providers of Medicare Advantage (MA) and Medicare Part D benefits with approximately 7.4 million members, we are distinguished by our near 30-year, long-standing, comprehensive commitment to Medicare beneficiaries across the United States.

Humana appreciates the opportunity to comment on October 28, 2015, HPMS memorandum "Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017." We thank CMS for releasing this proposal well in advance of the 45-day notice, but we believe the discussion would be improved if more details, including draft coefficients had been provided.

### **Request more details regarding the focus on dual eligibles**

The current proposal seeks to develop a model that includes separate community segments for the following six populations: 1) Full benefit dual aged; 2) Full benefit dual disabled; 3) Partial benefit dual aged; 4) Partial benefit dual disabled; 5) Non-dual aged; and 6) Non-dual disabled. CMS justifies the proposal because of both the increased focus of certain plans on exclusively serving the dual eligible population and because of payment accuracy concerns that CMS analysis indicates that "these subgroups have distinct cost profiles."

Absent additional discussion of CMS analytic methods, findings, and program and payment policy goals, Humana has concerns about the present proposal for the following reasons:

1. While it is true that plans focusing on subgroups (e.g., SNPs and PACE) have existed for some time, the statutory intent that risk adjustment “shall be applied uniformly without regard to the type of plan” has been the foundation of payment and benefits policies that have generally focused on supporting plans with broad risk pools.<sup>1</sup> This risk adjustment proposal and the memorandum language emphasizing plans that exclusively focus on dual eligibles suggest a shift away from that tradition without a discussion of the potential unintended consequences of such a change.
2. CMS has previously stated the policy goals of payment accuracy and “more payment equity across plans” for the 2014 model.<sup>2</sup> As presented, we believe this proposal does not promote equity between plans. This proposal appears to favor one plan type over others by transferring payments to plans focused on full benefit dual eligibles.
3. With respect to payment accuracy, we believe that justifying these subgroupings by virtue of their impact on predictive ratios alone is insufficient, without a discussion of other options. Predictive ratios tend to improve anytime the data are categorized from a heterogeneous population to a more homogeneous subgrouping. The current proposal did not provide a discussion of the analytic methods and/or policy reasoning for choosing dual eligible subgroupings over other subgroupings that could also increase predictive ratios. Previous rates notices have acknowledged concerns over non-dual subgroups (e.g., chronic disease subgroups), but this proposal does not address the reason for currently selecting one subgrouping over another or what the process would be for selecting additional subgroupings in the future.
4. In order to determine the net impact to any particular subgroup, we would need additional information from the Office of the Actuary regarding the impact of the proposed changes to the Medicare Advantage payment benchmarks.

#### **Potential sample size issues**

By stratifying the model into six subgroups, some potentially small sample sizes could come into play. CMS’ proposal reports that partial benefit dual – aged represent only 3.6% of the population, and partial benefit dual – disabled represent only 2.9% of the total population. CMS has previously expressed concern with sample size issues for the stability of estimates, albeit in the specific hierarchical condition categories (HCC) context.<sup>3</sup> We respectfully ask that CMS describe what methods the agency will use to ensure sample sizes are adequate for any subgrouping of the model now or in the future.

#### **Technical concerns with dual eligible data determinations**

The data on dual eligibles has traditionally been fluid. As CMS has noted in previous analytic work, different sources of duals status yield frequency variations ranging from 12.88% (Dual status code) to 19.37% (Medicare EDB HIC flag).<sup>4</sup> In addition, an examination of Humana data has found that over 390,000 dual status indicators have been added retroactively since January 2014. We believe that CMS should conduct additional analytic work to examine the impact of data reliability and retroactivity on model results and make the results of that analysis public.

There is also considerable churn in Medicaid eligibility in the dual eligible population. One study, found dual eligibles had annual rates of Medicaid disenrollment that averaged 5.4% each year.<sup>5</sup> This churn, in addition to the retroactivity around the operational flow of the data through CMS to plans, adds another layer of complexity to the payment process, especially when examined through the lens of this proposal. In particular, it is feasible that, at a member level, we could see multiple subgroups throughout the year and therefore payments processed through more than one model.

As always, we value the opportunity to provide comments and are pleased to answer any questions you may have.

## 47. Independent Care Health Plan (iCare)

Please accept the following comments to the proposed changes to the CMS-HCC Risk Adjustment model.

### 1. CMS COMMENT: Page 3, Research and Findings

In recent years, there has been an increased focus among some plans on exclusively serving the dual eligible population and CMS feels it is an appropriate time to revisit the model.

**iCare RESPONSE:** The new method is a significant and appreciated relief. However, there have always been plans focused on dual eligibles and these plans have known first hand that rates for duals were unsound from an actuarial perspective. These points have been made to CMS in the past by credible, nationally recognized actuarial firms. There have been an increased number of plans, e.g., Financial Alignment Demonstrations (FADs), focusing on dual eligibles; these plans are faced with rate inadequacy and will not survive without recognition that dual members are sicker and more costly. FADs are not unlike many other DSNP plans that preceded them in that regard. It is unfortunate that those features have not been recognized previously. The FADs are scheduled to get early relief on Part A and Part B expenses, effective January 1, 2016. Why FADs should be singled out and given preference over other DSNP plans is unclear. All plans serving duals need to be treated equally. It is disappointing to see CMS providing selective support, giving preference to some plans over others.

**iCare RECOMMENDATION:** Consider an early, perhaps retroactive, adjustment to all plans that serve disabled and aged duals, especially those who have served these members in prior periods.

### 2. CMS COMMENT: Page 3, Research and Findings

Community Segment. Our findings show that the community segment of the 2014 model predicts fairly accurately for non-dual eligible beneficiaries (PR=1.015) and somewhat over- predicts for partial benefit dual eligible beneficiaries (PR=1.092), while it somewhat under- predicts for full benefit dual eligible beneficiaries (PR=0.914) (see Table 1).

**iCare RESPONSE:** .914 is described as “SOMEWHAT under-predicting” for full benefit duals. In most financial circles this rate of under-prediction would be viewed as a serious error in method and judgment, and would be considered a “material” variance. Accepting the extreme pressure that CMS faces from the large national insurers, from congress, and from other departments, it would help strengthen respect for and the credibility of CMS actuaries to not minimize the significance of the miss.

**iCare RECOMMENDATION:** Replace “somewhat” with “material” when describing the under prediction.

### 3. CMS COMMENT: Page 3, Model Development

Specifically, rather than using a single segment for all community beneficiaries that includes factors for Medicaid status; we are developing a model that includes separate community segments for the following six populations:

- 1) Full benefit dual aged;
- 2) Full benefit dual disabled;
- 3) Partial benefit dual aged;
- 4) Partial benefit dual disabled;

5) Non-dual aged; and

6) Non-dual disabled.

**iCare RESPONSE:** It is not clear how an SSI member (a full benefit disabled dual eligible beneficiary) who qualified for Medicare because of his/her disability earlier in life and then ages past 65 will be classified under the new methodology. Is this SSI member (now over 65 years of age) a “Full benefit dual aged” or still a “Full benefit dual disabled”? This same transition issue may be true for the other categories.

**iCare RECOMMENDATION:** For members who originally qualified for Medicare as a Full benefit dual disabled, but then aged past 65, the appropriate classification should be “Full benefit dual aged” because their disabling condition is now made more complex by age, though this person is now both “disabled” and “aged”. Additionally, we will encourage CMS to retest its calibration of scoring for members were originally qualified for Medicare as disabled beneficiaries but are now also aged beneficiaries. We believe that this segment – “aged and disabled and dually eligible – remains under predicted.

**4. CMS COMMENT:** Page 4, Model Development,

We will also determine if it is statistically appropriate to distinguish between full and partial benefit duals. Similarly, we will explore the feasibility of revising the new enrollee model to distinguish between full and partial benefit duals.

**iCare RESPONSE:** There is no diagnostic based HCC adjustment available for first year enrollees under the current system unless the plan decides to turn on the option to accept full risk for all Part A enrollees in the Plan. In some cases, members join the plan when they first elect to join the Dual-Eligible MA program. In other cases, the member may join the FFS program for a period of time before electing to join a Medicare Advantage Plan. For the members in the FFS program, diagnostic information is known to be incomplete because providers are not reimbursed based on the completeness of their diagnostic reporting but on the services performed. Providers do not code to the specificity of the diagnosis code but to the most generic diagnosis code that is supported by their medical records. In addition, the providers do not submit all of diagnosis codes that they identify and document during the visit. The current CMS policy does not allow plans to retrospectively perform chart reviews and submit documented diagnosis codes that are not reported. As a result, this places the new plans at a reimbursement disadvantage and can result in incomplete care plans.

**iCare RECOMMENDATION:** To provide plans with an opportunity to ensure completeness in care of the individual and to ensure adequate compensation for new enrollees:

1. CMS should allow plans to perform retrospective medical record reviews and report the findings to CMS during the period that the member is not eligible with the plan, but during the period that would determine their current illness burden score.
2. CMS should review historical diagnosis code for members who have less than one year of activity to determine if the members’ short year diagnosis codes would more fairly present the member’s illness conditions to more accurately reflect future member experience. Or,
3. Develop new enrollee rates for each of the categories that would more reflect historical experience for the risk groups.

**5. CMS COMMENT:** Page 6, Initial Results of Revised Model:

Table 4: Comparison of Predictive Ratios by Deciles of Predicted Expenditures, Community Beneficiaries – 2014 Model and Revised CMS-HCC Model

**iCare RESPONSE:** Full benefit Dual Disabled in the 2nd and 3rd deciles remain significantly under predicted by 12% or more. CMS fully recognizes this shortcoming but offers no plan for correction other than to dismiss the shortcoming as immaterial.

**iCare RECOMMENDATION:** Adjust the model further to bring these deciles closer to 1.0.

**6. CMS COMMENT:** Page 7, Summary of Current Model Development Work:

We are not including the relative factors of the revised model in this solicitation for comment, since we have not completed our development work. We plan to include the factors in the 2017 Advance Notice and accept public comment on them through that vehicle.

**iCare RESPONSE:** If the method is truly underpaying now, should the underpayment be allowed to continue? If applied in 2017, should there be a correction to at least January 2016? Are not some financial alignment demonstrations already receiving a correction in anticipation of the new methodology?

**iCare RECOMMENDATION:** Make the adjustment effective January 2016.

Thank you for the opportunity to provide feedback on these important changes.

## **48. Inland Empire Health Plan (IEHP)**

Inland Empire Health Plan (IEHP) greatly appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) in response to CMS' Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017. IEHP is a not-for-profit, rapidly growing Medicare and Medicaid health plan in California. We are serving over 1.1 million residents of the Riverside and San Bernardino counties, including more than 23,000 dual eligibles. Our members are enrolled in Medicaid, the Medicare-Medicaid Plan (MMP) in the Financial Alignment Demonstration, and the Dual-Eligible Special Needs Plan (D-SNP).

In the October 28th memo, CMS confirmed that the Medicare Advantage (MA) risk-adjustment system under-predicts the costs of full-benefit dual eligibles. CMS also confirmed D-SNP and MMP members' experiences that there are cost differences between full-benefit and partial-benefit duals, and between disabled and aged individuals. Improving the accuracy of Medicare risk-adjustment for full-benefit dual eligibles will help D-SNPs and MMPs become more sustainable. Ultimately, D-SNP and MMP sustainability is a consumer issue. If D-SNPs or MMPs withdraw from the Medicare program due to payment inadequacy, full-benefit dual eligibles can experience a disruption in their continuity of care; they can lose access to the services and care coordination that are only available to them through integrated D-SNPs and MMPs; and they may have to navigate Medicare and Medicaid (including long-term care and behavioral health) on their own.

Given the importance of D-SNP and MMP sustainability to full-benefit dual eligibles, IEHP thanks CMS for evaluating and proposing ways to improve risk-adjustment for full-benefit duals. In addition, IEHP appreciates the analytic rigor of CMS' analysis and the agency's transparency in sharing the results, particularly the predictive ratios.

IEHP welcomes and supports CMS' proposal to improve the accuracy of risk-adjustment for full-benefit dual eligibles. We believe that CMS' proposal will improve the accuracy of the risk-adjustment model for full-benefit duals. This, in turn, will improve the sustainability of the D-SNPs and MMPs that enroll

these individuals. **IEHP asks CMS to implement the proposed changes to the risk-adjustment model for MA plans, including D-SNPs, in 2017. We also ask CMS to implement the proposed changes for MMPs in 2016.** Moreover, the risk-adjustment model's under-prediction of full-benefit dual eligibles has resulted in under-payments to plans for these beneficiaries. We ask CMS to make retrospective payment adjustments for MMPs and D-SNPs to reimburse plans for these under-payments for their full-benefit dual- eligible enrollees.

We also encourage CMS to continue its analysis of refinements to the institutional model and the new enrollee model. We look forward to seeing the results of those analyses. Further, we ask for more information on the disease interaction terms that CMS is considering should differ by model segment.

Finally, as CMS noted in the October 28th memo, the proposed changes do not fully eliminate the under-prediction for disabled dual-eligible individuals. We suspect the lack of mental health HCCs in the model may explain some of this continued under-prediction. We have found a high (30 to 44 percent) prevalence of mental health conditions among their full-benefit dual eligible enrollees. However, there are currently no HCC categories for depression, anxiety, or many other mental health conditions (e.g., PTSD and personality disorders). **Accordingly, we ask CMS to re-evaluate the model to assess the predictability of additional mental health conditions, such as depression and anxiety, on dual eligibles' costs and to add more mental health HCCs to the risk adjustment model to further improve the model's accuracy.**

## 49. InnovAge

Thank you for the opportunity to provide comments on the Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017. InnovAge is pleased to submit comments concerning CMS' proposal to develop risk factors for six distinct subpopulations of Medicare beneficiaries and changing the current Programs of All-Inclusive Care for the Elderly (PACE) organization HCC model (HCC v. 21) to the 2014 model being phased in for MA plans. InnovAge serves approximately 3,000 PACE participants in Colorado, California and New Mexico and over 90% of our clients are full benefit dual eligible beneficiaries.

In your recent October 28 memo on proposed changes, you specifically requested comments on whether CMS should apply the revised CMS-HCC model to payments for PACE organizations in 2017, in addition to Medicare Advantage plans. InnovAge strongly supports retaining the current PACE HCC v.21 model for PACE organizations, as this model more accurately predicts costs for Medicare beneficiaries who have dementia, congestive heart failure and early stage kidney disease.

Over half of our PACE participants have a diagnosis of dementia. The HCC codes 51 and 52 for beneficiaries with dementia that are included in v.21 are not included in the 2014 HCC model; excluding these codes would reduce the accuracy of payments to PACE organizations. In addition, the accuracy of the 2014 HCC model is further reduced when applied to PACE because of the lack of HCCs that acknowledge the interaction between early stage kidney disease and congestive heart failure. About a third of our clients have a diagnosis of congestive heart failure, and a significant number of these clients also have a diagnosis of an early stage kidney disease (HCC 138, 139, 140 or 141). Applying the 2014 HCC model would reduce the average HCC score for PACE beneficiaries with congestive heart failure and early stage kidney disease by about 20%. Finally, applying the 2014 model would eliminate HCCs for early stage pressure ulcers. By eliminating these HCCs, the model would not take into consideration the treatment required to prevent these ulcers from escalating.

In combination, applying the 2014 HCC risk adjustment model to PACE would result in a significant reduction of the CMS-HCC risk adjustment model's predictive value for a majority of PACE enrollees and would be financially devastating to PACE organizations, who care for the frailest and most costly Medicare clients.

Thank you again for the opportunity to provide input on the proposed changes; it is our hope that CMS will retain HCC v.21 for PACE. This model acknowledges the significance of dementia in predicting Medicare costs and appropriately recognizes the cost of care for PACE participants with early stage pressure ulcers and early stage kidney disease with congestive heart failure.

## **50. Itasca Medical Care**

I am the CFO for Itasca Medical Care. We are a D-SNP plan in Minnesota. Thank you for the opportunity to comment on the proposed changes to the CMS-HCC Risk Adjustment Model. We appreciate that you considering these changes to improve payment accuracy and agree that the current model doesn't reflect the needs of the dual population.

Our comments are as follows:

The Medicaid indicator is not always on new enrollees and can take a few months to be added. Will this status be retroactively applied back to the date of Medicaid enrollment?

The same is true that members sometimes lose Medicaid eligibility for up to 90 days. Some of them regain Medicaid eligibility retro back to the date of disenrollment from Medicaid. Again, will this Medicaid status be retroactively applied in this instance?

Additional comments: In addition to our original comments, we just wanted to add that Itasca Medical Care (H2417) supports the research that CMS is conducting regarding the accuracy of the CMS-HCC model introduced in 2014. Refining the model to more accurately account for the differences in cost profiles across the various community segments, as shown by the predictive ratios, will better align total costs and revenues. In addition, the proposed model would make significant improvements at both the high-cost and low-cost extremes thus improving the viability of dual-eligible Special Needs Plans.

## **51. Justice in Aging**

Justice in Aging (formerly the National Senior Citizens Law Center) appreciates the opportunity to provide comments on the proposed changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017.

Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on long-term services and supports and the particular needs of dual eligible individuals.

We appreciate the careful and thorough approach that the Centers for Medicare and Medicaid Services (CMS) has taken in exploring the accuracy of the CMS-Hierarchical Condition Category (HCC) risk adjustment model for predicting the cost of care for dual eligible individuals. We support developing a model that is based on a more granular analysis of cost and utilization data. We hope that a more nuanced payment model will encourage the retention of high- quality plans to serve Medicare and Medicaid beneficiaries and promote genuinely person- centered care.



As CMS develops the revised model, we ask the agency to take care that any payment changes based on the analysis do not have the unintended consequence of disincentivizing community-based services because of higher rates for individuals residing in institutions. Increasing access to home and community-based services is a central goal of current health care delivery system reform efforts.

We commend CMS for the agency's transparency during the exploration of the HCC risk adjustment model and for facilitating a robust stakeholder comment and review.

Thank you for the opportunity to comment on the proposal.

## **52. Kaiser Permanente**

How are Community members going to be identified as being in one of the six categories being developed? Are new RAFT/Factor types going to be created for these six categories?

## **53. Kaiser Permanente**

Kaiser Permanente<sup>1</sup> appreciates the opportunity to provide initial comments in response to CMS' proposed changes to the CMS-HCC risk adjustment model.

We are particularly appreciative of CMS' willingness to offer Medicare Advantage Organizations (MAOs) insight into the agency's ongoing analysis and the policy changes under consideration in advance of their formal proposal in the 2017 Advance Notice. Additionally, we are generally supportive of proposals that will improve the accuracy of the risk adjustment model. Kaiser Permanente has always supported the development and use of an accurate risk adjustment model that includes the diagnoses that appropriately reflect the disease burden of plan members and coefficients that appropriately compensate plans for the care their members need.

While we support CMS' transparency in sharing its conceptual proposal, we are unable to provide complete comments at this time given the lack of information about coefficients that would be used in the six new community segments. We cannot validate CMS' statements that the proposal would improve the predictive accuracy of the model. We urge CMS to make available to MAOs as soon as possible any underlying analysis or modeling supporting its proposal so that MAOs can better understand the potential impact. We also ask that, if CMS proceeds with its proposals, the agency make available the coefficients and relative factors for the new models as early as practicable in order to begin the significant amount of work needed to model, assess impacts and make meaningful comments on the Advance Notice, and then to accurately forecast risk scores for the 2017 bids.

Kaiser Permanente Comments CMS-HCC 2017 Proposed Changes

Based on the limited analysis we have been able to perform with the predictive ratios CMS included in its proposal, we are very concerned that the changes to the CMS-HCC model would not be revenue-neutral to the MA program. Comparing the high level predictive ratios of the current model to those the proposed model shows that overall payments to MAOs might be reduced instead of simply shifted among non-duals and partial- and full-benefit duals. This is due to the fact that the proportion of partial- and full-benefit duals in MA is lower than in original Medicare, on which the ratios are based. The ratios suggest there may be more revenue reductions for the non-dual portion of the MA population than there are revenue increases for the partial- and full-benefit dual MA enrollees. If this is an outcome of the new model, it would effectively be another fee-for-service (FFS) based adjustment to MA payments, akin to the coding intensity factor.

Given the large and growing proportion of Medicare beneficiaries enrolled through MA, it is critically important that CMS policies support the continued stability and high quality of the program. For the last several years, the CMS-HCC risk adjustment model has been a key lever for the agency in terms of adjusting overall payments to MAOs. In particular, the full implementation of the 2014 CMS-HCC model for 2016 will mean a further reduction to risk-adjusted payments for many plans due to the removal of certain diagnoses and disease interactions in the clinical model. This administrative reduction in payments is on top of the hundreds of billions of dollars in legislated payment cuts that will be completely implemented by 2017. Meanwhile, the lower health care cost trends seen a few years ago have begun to reverse, making it increasingly difficult for MAOs to provide affordable plan options for beneficiaries.

We urge CMS not to put further downward pressure on MA payment rates by removing revenue through another FFS-based adjustment. Any change to the risk adjustment model should be revenue-neutral to the MA program. We also request that CMS provide analysis on the expected impact of its proposals on funding to the MA program as a whole and expected ranges of plan-level impact, including data elements that allow the industry to validate CMS' findings.

Kaiser Permanente appreciates CMS' consideration of these comments.

## **54. L.A. Care Health Plan**

Thank you for the opportunity to comment on the October 28, 2015 memorandum entitled "Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017". We have two comments for your consideration.

### **1) Baseline Cost Estimates in Dual Demonstration**

According to the CMS document Joint Rate-Setting Process for the Capitated Financial Alignment Model, updated August 9, 2013, which describes the joint rate-setting process for Medicare-Medicaid plan (MMP) capitated financial alignment model, the baseline spending for the target population [full benefit dual eligibles] was to be "an estimate of what would have been spent in the payment year had the demonstration not existed".

CMS did not set the baseline spending based on the target population and instead set the baseline spending on all Medicare beneficiaries. As explained in the analysis summarized in the October 28, 2015 memo, this created a significant shortfall in the rates paid to health plans for full benefit, dual eligible demonstration members.

In a separate memorandum regarding the MMPs dated November 12, 2015, CMS indicated it plans "...to better align MMP payments with FFS costs for full benefit dual eligible beneficiaries. Such updates will apply for all twelve months of CY 2016."

We request the following information to assist in our evaluation of the proposed change to the risk adjuster:

A report of the member counts split into the six subgroups in Table 2 of the October 28, 2015 memorandum, plus the institutional population by county, for a total of seven subgroups. In addition to the member counts, we request the actual per member per month costs and risk scores.

### **2) Institutionalized Population**

The October 28th memorandum provided little information on the institutionalized population, stating only that it predicts very well.

We are interested in receiving more information on this population and would like CMS to release a report with the analysis which led them to conclude that the risk adjuster predicts well. In addition to the analysis, we request a list of the member IDs considered to be institutionalized members in the Medicare 5% sample to allow for an independent review of this finding.

## **55. Life Pittsburg**

This constitutes the response of LIFE Pittsburg to CMS' request for comment on the proposed changes to the HCC risk adjustment methodology.

### **Background**

LIFE Pittsburg is a Program of All-Inclusive Care for the Elderly that has operated in Pittsburgh, Pennsylvania for over 17 years. We serve 575 individuals with significant complex chronic conditions and functional or cognitive impairment. All of our participants meet the state's definition of requiring a nursing home level-of-care. Approximately 51% of our enrollees have dementia.

We appreciate CMS' consideration of the following comments and recommendations: Comments

- 1) LIFE Pittsburg believes that developing risk factors for six distinct subpopulations of Medicare beneficiaries to acknowledge the impact of Medicaid eligibility status, along with institutional vs. community residence, will improve the accuracy of the risk adjustment system. LIFE Pittsburg supports the use of the subpopulations' distinct risk factors for establishing payments to PACE organizations. LIFE Pittsburg notes that approximately 98.6% of our enrollees are fully dual-eligible for Medicare and Medicaid.
- 2) In addition to calculating risk factors for the six distinct subpopulations of Medicare beneficiaries, CMS requests comments on changing the current PACE HCC model (HCC v. 21) to the 2014 model being phased in for MA plans (the "2014 model"). LIFE Pittsburg, as we have stated previously in response to CMS' 2013 advance notice of payment when it initially proposed the 2014 model, strongly recommends retaining the current PACE HCC model (HCC v.21) for PACE organizations. Shifting PACE to the 2014 model will reduce the performance of the risk adjustment model for PACE enrollees relative to the model that is currently in place.

The Evaluation of the CMS-HCC Risk Adjustment Model completed for CMS by RTI and released in March, 2011 assessed the predictive ratio of the CMS-HCC risk adjustment model v.21 relative to an earlier version, v.12. The evaluation found that v.21 accurately predicts costs for Medicare beneficiaries and, in particular, significantly improved model performance over v.12 for beneficiaries with dementia.

Nearly 51% of all LIFE Pittsburg enrollees have dementia, as of August, 2015. The HCCs (51 and 52) for beneficiaries with dementia that are included in v. 21 and are related to its improved predictive value in comparison to v. 12 are not in the 2014 HCC model. Because of the significance of dementia in the PACE enrollee population, we provide detailed comments on this condition and the impact of its removal from the HCC risk adjustment model below.

Further reducing the 2014 HCC model's accuracy when applied to PACE is its lack of HCCs that support the identification of interactions between early stages of kidney disease and congestive heart failure. Approximately 36.1% of LIFE Pittsburg enrollees have a diagnosis of CHF, and of these 17.1% are diagnosed with an early stage kidney disease (HCC 138, 139, 140 or 141). We

have estimated that the 2014 HCC model would reduce the average HCC score for LIFE Pittsburgh beneficiaries with congestive heart failure and early stage kidney disease by 20%.

In combination, the 2014 HCC risk adjustment model results in a significant degradation of the CMS-HCC risk adjustment model's predictive value for the large majority of PACE enrollees.

3) The CMS-HCC risk adjustment model for PACE enrollees needs to include dementia.

Because of the significance of dementia for the cost and care of LIFE Pittsburgh participants, the CMS-HCC risk adjustment model for PACE needs to include HCCs for dementia diagnoses. As noted earlier, approximately 51% of LIFE Pittsburgh participants are diagnosed with dementia, as indicated by the percent triggering either HCC51 or HCC52 for dementia in the CMS-HCC risk adjustment model currently applied to PACE (v.21).

Removal of dementia related HCCs from the risk adjustment model significantly reduces the predictive ratio of the model for these PACE enrollees and, as a result, will undermine the financial sustainability of PACE programs.

Risk adjustment without HCCs for dementia results in substantial under prediction of the costs of care for enrollees with dementia, who comprise a large proportion of PACE organizations' total enrollment.

Referring to the Evaluation of the CMS-HCC Risk Adjustment Model that CMS released in March 2011, RTI compared predictive ratios for HCC chronic disease groups and concluded that v.21 of the CMS-HCC model was far superior to v.12 in predicting costs for beneficiaries with dementia. For beneficiaries with dementia, v.21 (with HCCs for dementia) of the model achieved a predictive ratio of 1.000 compared to 0.858 for v.12, which like the 2014 model used for MA plans lacks HCCs for dementia. This indicates that predicted costs for beneficiaries with dementia under v.12 are essentially 14% lower than actual costs. Based on historical diagnostic data, NPA's comparison of PACE organizations' mean HCC scores for PACE enrollees with dementia in the v21 model vs. the 2014 model used for MA plans indicates that the 2014 model generates mean HCC scores that are, on average, 21% lower than v.21. We are deeply concerned that exclusion of dementia HCCs in the 2014 model leads to substantial underpayment for PACE enrollees with dementia. These individuals account for almost half of all PACE enrollees.

Failure to recognize dementia related costs is not consistent with CMS efforts to serve more people needing long-term services and supports through health plan options.

As CMS and states seek to enroll more people needing long-term services and supports in managed care options, the impact of under predicting costs associated with dementia will be broader than PACE. While for most Medicare Advantage plans the current prevalence of dementia is low, resulting in a minimal financial loss associated with the removal of dementia as a risk factor, the impact on PACE and other emerging options for people who need long-term services and supports, a large proportion of whom will have dementia, will be much greater.

4) Retaining the current PACE HCC model (v. 21) will reflect the costs of preventing early stage pressure ulcers.

A shift to the 2014 model would eliminate HCCs for pressure ulcers categorized as stage 1 or 2. Without these HCCs, the risk adjustment model would not take into consideration the care

planning and treatment required in order to prevent these ulcers from escalating to a stage 3 or 4 ulcer. In the frail population served by PACE, individuals' compromised skin condition along with coexisting medical conditions such as diabetes and peripheral vascular disease often lead to the development of pressure ulcers. The early interventions PACE organizations provide avoid lower stage ulcers from progressing to stage 3 or 4 ulcers. If not prevented, these higher stage ulcers can require high cost procedures, hospitalizations and in some cases may lead to death. The HCC model for PACE should recognize, and incentivize, the investment in prevention made in caring for people with stage 1 and 2 ulcers.

Recommendations

### **1. Retain the current v.21 of the CMS-HCC risk adjustment model for PACE**

NPA strongly recommends that CMS retain the current v.21 CMS-HCC risk adjustment model used for PACE payment. This HCC model recognizes the importance of dementia in predicting Medicare costs. In addition, this model appropriately reflects the costs of care for PACE participants with early stage pressure ulcers and early stage kidney disease that is comorbid with congestive heart failure. The combination of PACE county payment rates, the current v.21 CMS-HCC risk adjustment model and frailty adjustment generates appropriate payment for our high cost population of Medicare beneficiaries.

This assessment is based in part on an analysis, previously shared with CMS by the National PACE Association, undertaken in response to CMS' implementation of the frailty adjustment model applied to PACE beginning in 2008. The study identified a PACE-like population from among respondents to the National Long Term Care Survey (NLTC) and compares their observed costs in FFS to the costs predicted by the v.12 CMS-HCC risk adjustment model and revised frailty adjustment model. The study concluded their payments were substantially under predicted. A significant proportion of this under prediction was addressed by implementation of the v.21 model in CY2012 and further addressed by implementation of the recalibrated frailty adjustment model in CY2013. Applying the MA 2014 model to PACE will undo the improvements in the risk adjustment methodology for PACE that have been achieved to date.

### **2. Apply distinct risk factors for the subpopulations of Medicare beneficiaries described in the request for comment to the calculation of payments for PACE organizations.**

We concur with CMS that dual-eligible status is a strong determinant of costs to the Medicare program. Establishing distinct risk factors for populations based on this eligibility status, along with institutional vs. community residence status, will improve the accuracy of the payment methodology for PACE.

In addition to the improved performance relative to the MA 2014 CMS-HCC risk adjustment model, retaining the v.21 model offers the benefit of payment stability for PACE organizations. As comparatively small, not for profit organizations, PACE programs are particularly compromised in their ability to make financial commitments regarding developing and operating PACE by stark annual changes in Medicare's payment methodology.

## **56. Maricopa Care Advantage Inc. (MCA)**

The University of Arizona Health Plans and Maricopa Care Advantage (MCA) Inc. greatly appreciate the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) in response to CMS' Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017. Maricopa County Special Health Care District (d/b/a Maricopa Health Plan, operates as a Medicaid health plan in

## Comments on Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017

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Maricopa County) was certified on February 14, 2013 by the Arizona Health Care Cost Containment System (AHCCCS) - the Arizona Medicaid regulatory agency, per regulatory authority, as a contractor for Medicare purposes in lieu of Arizona Department of Insurance Licensure. The Maricopa County Special Health Care District Medicare plan, in turn, serves to satisfy the Medicaid contract requirements for Maricopa County Special Health Care District by offering dual eligible members with direct access to a MAPD Dual-Eligible Special Needs Plan.

The primary objective of Maricopa County Special Health Care District (which for its Medicare Advantage Plan will be doing business as Maricopa Care Advantage -MCA) Dual Special Needs Plan (D-SNP), is to offer a product that will meet the beneficiaries' financial and health care needs as well as ensure coordination of care for them. This means:

- Identifying eligible members and their needs,
- Enrolling and retaining sufficient membership of dual eligible beneficiaries to maintain financial viability,
- Provide all dual eligible beneficiaries with the highest level of customer care,
- Actively manage and coordinate care.

Since MCA operates as an integrated D-SNP for those members enrolled in both the MA SNP and the Medicaid managed care plan, this allows for better coordination of benefits, payments and care. Just as important, MCA strives to provide beneficiaries and their families with easy-to-understand information, provide trained personnel to answer questions and provide assistance in navigating through the process and ensure that their access to health care through AHCCCS and Medicare is as trouble-free as possible. To this, MCA stresses the benefit of the local health plan, which includes preventive care and comprehensive care coordination through the direction of primary care providers as well as access to a reputable provider network. We believe that through our benefit offerings, zero premium, access to care and commitment to serving our community, we are able to provide a very attractive value and product. Specific to the special needs dual eligible population, we recognize that these beneficiaries often do not have access to coordinated care and a dedicated primary care provider. The opportunity for dual eligible members to join and become a member of a well-respected health plan, as well as to have access to a premier provider network will be an attractive incentive to potential members. Further, existing dual eligible members are able to continue seeing their current providers.

In the October 28th memo, CMS confirmed MCA's experience, that the Medicare Advantage (MA) risk-adjustment system under-predicts the costs of full-benefit dual eligibles. CMS also confirmed MCA's experiences that there are cost differences between full-benefit and partial-benefit duals, and between disabled and aged individuals. MCA strongly supports improving the accuracy of Medicare risk-adjustment for full-benefit duals. It is consistent with the fundamental tenant of risk adjustment to adequately fund health plans so that they may provide high quality and cost appropriate health care to members at a level commensurate with their health status.

Given the importance of D-SNP's ability to maintain the financial viability with full-benefit dual eligible, MCA thanks CMS for evaluating and proposing ways to improve risk-adjustment for full-benefit duals. In addition, MCA appreciates the analytic rigor of CMS' analysis and the agency's transparency in sharing the results, particularly the predictive ratios.

MCA believes that CMS' proposal will improve the accuracy of the risk-adjustment model for full-benefit duals. Given the significant credibility of the results of CMS' analysis, MCA asks CMS to implement the proposed changes to the risk-adjustment model for MA plans, including D-SNPs, in 2016. Moreover, the risk-adjustment model's under-prediction of full-benefit dual eligibles has resulted in

under-payments to plans for these beneficiaries. We ask CMS to make retrospective payment adjustments for D-SNPs to reimburse plans for these under-payments for their full-benefit dual-eligible enrollees. We also encourage CMS to continue its analysis of refinements to the institutional model and the new enrollee model. We look forward to seeing the results of those analyses. Further, we ask for more information on the disease interaction terms that CMS is considering should differ by model segment.

Finally, as CMS noted in the October 28th memo, the proposed challenges do not fully eliminate the under-prediction for disabled dual-eligible individuals. We suspect the lack of mental health HCCs in the model may explain some of this continued under-prediction. However, there are currently no HCC categories for depression, anxiety, or many other mental health conditions (e.g., PTSD and personality disorders). Given the national focus on the importance of integrated care, especially for members with co-morbid conditions, our health plan has developed specific programs for many of our dual eligible members due to their behavioral health conditions. Currently, fifty-three percent (53%) of our MCA members have a diagnosed mental health condition. In supporting these members, we have found through our care coordination activities, including the completion of the Health Risk Assessment, that many of these members with behavioral health conditions are not accessing behavioral health services to improve their symptoms. These undetected and untreated behavioral health conditions have a direct impact on their ability to manage their physical health care conditions. Additionally, our health plan provides high touch case management and outreach to these members to engage them in services and refer them to community services to address their social determinants of health to include lack of housing, natural supports, access to local resources and other services that could support their improved health care outcomes and ultimately reduce health care costs. Our ability to implement this type of intervention is rapidly becoming cost prohibitive due to the current risk- adjustment model. Accordingly, we ask CMS to re-evaluate the model to assess the predictability of additional mental health conditions, such as depression and anxiety, on dual eligibles' costs and to add more mental health HCCs to the risk-adjustment model to further improve the model's accuracy.

MCA is prepared to assist with additional information, if needed.

## **57. Massachusetts Office of Medicaid (MassHealth)**

On behalf of the Office of Medicaid of the Executive Office of Health and Human Services (EOHHS), we appreciate the opportunity to provide feedback on CMS's proposed approach, dated October 28, 2015, to revising the CMS-HCC risk adjustment model to better predict costs for beneficiaries based on their dual status and aged/disabled status for Payment Year 2017.

MassHealth is the Massachusetts Medicaid and CHIP program. MassHealth provides coverage to approximately 300,000 individuals who also have Medicare (dual eligibles), including approximately 275,000 (92%) Full Benefit and approximately 8,000 (8%) Partial Benefit dual eligible members. While most of our dual eligible members are served through fee-for-service, a growing number (almost entirely Full Benefit dual eligibles) are served through managed integrated or coordinated care delivery systems, including approximately 12,000 adults with disabilities in Medicare-Medicaid Plans (MMPs) under a Financial Alignment Demonstration (One Care), approximately 4,000 in Programs of All Inclusive Care for the Elderly (PACE), and approximately 40,000 in a coordinated D-SNP model for members ages 65 and older (Senior Care Options - SCO).

Earlier this fall, one of Massachusetts' three MMPs withdrew from One Care, citing unsustainable finances as the key factor in their decision. Medicare rates that did not fully reflect the risk of their

enrolled population was an important factor in their program finances. We appreciate the collaborative approach that CMS has taken to understanding and addressing these issues together with the Commonwealth. CMS recognized the limitations of the risk adjustment methodology and other challenges in the One Care program's financing structure and is working with us to improve the accuracy of Medicare and MassHealth rates. This change is critical to putting One Care back on a sustainable path.

We are pleased that CMS has undertaken this analysis, and the findings confirm that the current risk adjustment tool is not calibrated to accurately estimate and pay adequately for the needs of Full Benefit dual eligible members. The analysis shows that the current risk adjustment model has underestimated the risk of these members, resulting in rates that are estimated to be, on average, (5.3%) lower than they should be for One Care members and (10.8%) lower than they should be for SCO members.

We strongly support CMS' proposed revisions to the CMS-HCC model. We encourage CMS to implement these revisions for MMPs in January 2016, and for at least D-SNP plans, if not fully for all Medicare Advantage and Special Needs Plans, in January 2017. The timely implementation of these changes to risk adjustment and payment is critical to ensuring the Massachusetts marketplace continues to have plans that will serve these very vulnerable populations.

We support CMS's approach of identifying six distinct groups for Medicare beneficiaries residing in the community. Per CMS's published comparison, the revised model would result in significantly improved accuracy for each of the six groups. However, we respectfully ask CMS to continue testing revisions to more accurately pay for the costs of Full Benefit dual eligibles in each decile. Specifically, we continue to be concerned that the behavioral health needs of Medicare beneficiaries and the needs of those with multiple chronic health conditions are not accurately captured in the CMS-HCC model.

We also respectfully ask CMS to consider doing a similar analysis and consider potential revisions to the Part D RxHCC model for dual eligible beneficiaries and to share that analysis with states.

CMS currently uses a different version of the CMS-HCC model to pay PACE organizations. It is our understanding the CMS-HCC model used for PACE incorporated frailty factors based on limitation in Activities of Daily Living (ADL). It is unclear if the proposal to use the revised CMS-HCC model for PACE would replace the use of the frailty factors or if they would be used in combination. It would be helpful to see an analysis of the predictive ratios of each approach for PACE beneficiaries. We would also ask that CMS clarify any proposed change for PACE with respect to the application of the frailty factors.

We thank you for your partnership and for your consideration of our comments, and we look forward to continuing to work with the federal government to strengthen and improve care for our most vulnerable members.

## **58. Medica**

Thank you for the opportunity to provide comments in response to the Centers for Medicare & Medicaid Services' ("CMS") proposed changes to the CMS-HCC risk adjustment model for payment year 2017 published October 28, 2015 ("proposed model"). Medica<sup>1</sup> (also referred to as "we" or "our") is an independent and nonprofit health care organization with approximately 1.5 million members, and is Minnesota's second largest nonprofit provider of health insurance and related services. Medica proudly serves 10,000 enrollees in the Minnesota Senior Health Options program, a fully integrated dual eligible special needs plan ("SNP"). Medica's mission is to work with members and its contracted providers to make health care accessible, affordable and a means by which our members improve their health.



Our comments and recommendations to the proposed model are divided into two categories and address the proposed modifications to the model and why CMS' underlying assumptions regarding the costs of the SNP members also substantiates the need to modify the Medicare Advantage ("MA") Star Measurements.

Accordingly, on behalf of Medica, I respectfully submit the following comments to CMS:

**I. Medica supports CMS' proposed changes to the Medicare Advantage CMS-HCC risk adjustment model for payment year 2017.**

Medica supports CMS' proposed framework to correct the risk model. From a policy perspective, the proposed corrections will reverse the systematic under-payment for dual-eligible beneficiaries who represent the poorest, sickest, most expensive and most vulnerable populations in the health care system. Conceptually, we support CMS' proposal to restructure the current risk adjustment model to include six separate community segments to more accurately reflect the subgroups' distinct disease and cost profiles. We appreciate CMS' efforts to acknowledge and equitably address the unique population of SNP enrollees and the impact of their needs on the health plans who serve them.

We generally believe the proposed categorization in the risk adjustment model is appropriate to account for the financial differences in the populations for two reasons. First, Table 2 of CMS' proposal shows that annual per capita fee-for-service spending for the populations differs by a factor of 2:1, indicating that a single set of HCC coefficients are not sufficient to account for high cost enrollees.

Second, long-standing research shows that SNPs serve populations with greater barriers and challenges, such as lower health status and socio-demographic characteristics, which warrants attention to the accuracy of Medicare payments for their care. Under CMS' proposal, the IICC model would accurately pay for each population segment and for each HCC under each segment. Thus, Medica believes the proposal creates appropriate financial incentives for all MA plans to maintain the health and wellbeing of poor, disabled, and elderly enrollees.

Although Medica supports the proposed revisions, we respectfully request CMS release information about the HCC coefficients as soon as possible to enable plans to completely assess the model and its impacts. The information available in the proposed model allowed us to assess the directional financial impact, but the HCC coefficients for each segment are necessary to determine the detailed impact of the proposed changes.

**II. Medica strongly supports CMS revising the Star Measures for SNPs, and CMS's rationale for modifying the CMS-HCC risk adjustment model also substantiates the need to alter the Star Measures for SNPs.**

CMS is proposing to segment the Medicare Advantage CMS-HCC risk adjustment model into six populations groups, divided into the SNP plan type, disability and age, because of the distinct subpopulation costs.

The proposed changes to the risk adjustment model are attributable to the unique populations served by SNPs, which generally include the aged low-income, or disabled low-income. More than half of the dual-eligible enrollees have annual incomes of less than \$10,000. In Medicare, only 8% have similar incomes. Enrollees in dual-eligible SNPs are more likely to be disabled, live in an institution, and report poor health status. <sup>2</sup>CMS' proposed model separates the SNP population into the type of plan eligibility (full dual-eligibility, partial dual-eligibility, or none), and further segments those three groups by "aged" and "disabled." By doing so, CMS acknowledges the financial challenges associated with income, age, and disability.

## Comments on Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017

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This unique population mix, those with lower income, the older, and the disabled, results in, generally, worse Star Measure ratings:<sup>3</sup>

Clinical and sociodemographic and community resource factors are significantly associated with worse outcomes among dual eligible members accounting for at least 70% of observed disparities in outcomes for seven Star measures. The results indicate that if these Star Measures were statistically adjusted for the risk factors found to be significantly associated with worse outcomes, the observed disparities in Star Measure scores could be reduced by 70% or more.<sup>4</sup>

We believe the CMS modifications to the HCC risk adjustment model offer a blueprint for modifications to the MA Star Rating Measures. Medica appreciates CMS's undertaking on this project and welcomes future discussions on how this approach may be applied to the Star Rating Measures in a manner that is fair and equitable.

As a plan with both a Medicare Cost Plan and a Dual Eligible Special Needs Plan (D-SNP), Medica is in the position to compare and analyze plan performance in quality measures. Medica Prime Solution (H2450) is Medica's Cost plan, offered in Minnesota, western Wisconsin, North Dakota and South Dakota. Medica Prime Solution provides a range of affordable medical and Part D options that work with Original Medicare by covering important costs that Medicare does not. Medica DUAL Solution is a D-SNP, offered in 33 counties in Minnesota in 2014. DUAL Solution began as a demonstration project in 1997 and was converted to a D-SNP in 2008. It is a fully integrated dual eligible type of D-SNP where the member receives one member card and all services and claims including Medicaid, Medicare, and Part D benefits are managed by Medica.

A review of the most recent Medicare Health Outcomes Survey ("HOS") shows the distinct differences in the member demographics between these two plans. As compared to the Cost Plan, Medica's DUAL Solution members are older and more frail. Over 50 percent (51.7%) of the DUAL Solution members surveyed for the HOS survey are over 80 years old, as compared to 28.9% of Cost Plan members. Additionally, 52.3% of members surveyed have two or more impairments with Activities of Daily living, as compared to 15.6% of members in the Cost Plan at Medica. Medica has completed a comparison of the plan performance of both the Cost Plan and D-SNP plans across several measures.

We have analyzed the performance of our two populations on five performance measures. The analysis shows that the differences in reported rates are independent of population differences in illness burden and service utilization, and are not likely to be a result of differences in quality of care. As such, Medica recommends that the dual eligible plans be measured against other dual eligible plans.

Thank you once again for the opportunity to provide these comments. Please do not hesitate to contact me if you have any questions or would like to discuss Medica's comments in more detail.

<sup>1</sup> "Medica" refers to the family of health plan businesses that includes Medica Health Plans, Medica Health Plans of Wisconsin, Medica Insurance Company, Medica Self-Insured and Medica Health Management, LLC, as well as sister organizations Medica Foundation and the Medica Research Institute. <sup>2</sup>Health Policy Brief from Health Affairs, "Care for Dual Eligibles," (June 13, 2011), available at [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=70](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=70). <sup>3</sup>The Medicare Payment Advisory Commission ("MEDPAC") found "[i]n the 2015 star ratings, of the last six contracts whose enrollment of beneficiaries under age 65 was more than thirty percent as of December 2012, there are no contracts with a star rating higher than 3.5. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS MEDICARE PAYMENT POLICY 338 (Mar. 2015), available at [http://www.medpac.gov/documents/reports/mar2015\\_entirereport\\_revised.pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/mar2015_entirereport_revised.pdf?sfvrsn=0). MEDPAC note an association between a plan's Star Ratings and the share of Medicare Advantage enrollees in a plan who are

under age 65 and low-income. Id. at 317. <sup>4</sup> INOVALON, AN INVESTIGATION OF MEDICARE ADVANTAGE DUAL ELIGIBLE MEMBER-LEVEL PERFORMANCE ON CMS FIVE-STAR QUALITY MEASURES 9 (2015), available at <http://resources.inovalon.com/h/i/60106948-an-investigation-of-medicare-advantage-dual-eligible-member-level-performance-on-cms-five-star-quality-measures>.

## **59. Medicaid Health Plans of America (MHPA)**

On behalf of Medicaid Health Plans of America (MHPA), we thank you for this opportunity to provide comments on the revised CMS-Hierarchical Condition Category (HCC) model for Payment Year (PY) 2017. In response to the Centers for Medicare and Medicaid Services' (CMS) request for feedback around the proposed changes to the HCC model, MHPA would like to share some thoughts about how the model will impact Medicare-Medicaid Plans (MMPs) and Dual Eligible Special Need Plans (D-SNPs).

MHPA is the leading national trade association representing Medicaid managed care plans, ranging from multi-state, for-profit plans to small, non-profit plans. MHPA's 124 health plan members serve the nation's poorest, most vulnerable population across 34 states and D.C, including dual eligibles through MMPs and D-SNPs in the Financial Alignment Demonstration .

MHPA supports CMS' efforts to adjust the HCC risk adjustment model to account for the disproportionate impact of certain populations, like dual eligibles, on the community segment of the model. Our members are appreciative of CMS' recognition of the inherent differences in providing care to dual eligibles as compared to the overall Medicare Advantage (MA) population and believe the revisions to the model should also be applied to Medicare-Medicaid demonstration programs. We request that CMS consider the following comments and suggestions in preparation for the 2017 Advance Notice.

### **Timing Concerns for Modeling Seven Cohorts During 14-Day Comment Period for Advance Notice**

MHPA appreciates CMS' effort to make the HCC risk adjustment mode more accurate by expanding the community segment to six population subgroups. Combined with the institutional segment, health plans must model seven different cohorts during the 14-day comment period for the 2017 Advance Notice. We are concerned that the 14-day period will not provide enough time to model each cohort in order to provide meaningful feedback in the comment letter for the Advance Notice. In order to provide the most meaningful feedback possible, we request that CMS extend the comment period for the Advance Notice to accommodate the modeling of each cohort or release the HCCs prior to the release of the Advance Notice.

### **CMS Should Not Revise the Hierarchical Condition Categories or Differentiate the Interaction Terms**

In the memorandum, CMS noted that the proposed model will not involve a clinical revision of the HCCs. MHPA is supportive of this decision. We believe that the proposed expansion of the community segment is a significant change that will require time to model to provide meaningful feedback. MHPA recommends that CMS consider a clinical revision of the HCCs in subsequent revisions of the model. During that time, MHPA recommends that CMS consider adding HCCs for mental health, which may alleviate the continuing under-prediction for disabled dual-eligible enrollees given their disproportionately high prevalence of mental health conditions, including depression and anxiety.

Additionally, CMS requested comment around whether the disease interaction terms should differ by model segment. In this iteration of the model revisions, we believe that CMS should not differ the interaction terms by model segment.

### **Determining Dual Eligible Status on Monthly Basis May Not be Operationally Feasible**

While we are supportive of the concept of concurrent payments in the proposed model, we are concerned that this switch may not be operationally feasible as it can be quite challenging to determine dual eligible status when individuals churn between partial- benefit and dual-benefit dual status. Additionally, it can be difficult to determine dual eligible status with the Medicaid Management Information System (MMIS) as a result of incomplete or inaccurate enrollee information . In many instances, health plans may have more current information than what is contained in MMIS. In light of the complexities that may be experienced when determining dual eligible status, despite the proposed changes, we are still concerned that plans may not be adequately compensated .

MHPA appreciates CMS' effort to revise the HCC risk adjustment model to reflect impact of certain populations, like dual eligibles, on the community segment of the model. As you work to finalize the revisions, MHPA and our member health plans are happy to serve as an information resource.

## **60. MedPAC**

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Request for Comment memorandum entitled "Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017" issued by the Medicare Plan Payment Group on October 28, 2015. The memorandum proposes changes to improve the way that the Medicare Advantage (MA) risk-adjustment system determines payments for Medicare/Medicaid dually-eligible beneficiaries. We appreciate your staff's ongoing efforts to administer and improve payment systems for MA, particularly considering the competing demands on the agency.

The memorandum correctly notes that MedPAC has had concerns about the accuracy of the CMS-Hierarchical Condition Category (CMS-HCC) risk adjustment model for predicting costs of dually-eligible beneficiaries. The Commission's specific concern is that beneficiaries with full-dual eligibility (those beneficiaries eligible for full Medicaid benefits) incur significantly higher costs than beneficiaries with partial-dual eligibility (those whose Medicaid benefit consists only of assistance with Medicare premiums and, in some cases, Medicare cost sharing). Currently, the CMS-HCC system uses a single adjustment factor for dual eligibility status that is applied to both full- and partial-benefit dually eligible beneficiaries.

In place of this single adjustment, CMS proposes to use six separate models for community dwelling beneficiaries based on different categories of dual eligibility and reason for entitlement (aged or disabled), consistent with our concerns. CMS would continue to use a separate model for beneficiaries who have been in an institution for 90 days or longer. The CMS-HCC risk scores for community dwelling beneficiaries would be modeled separately for each of the following six groups:

1. Full benefit dual aged;
2. Full benefit dual disabled;
3. Partial benefit dual aged;
4. Partial benefit dual disabled;
5. Non-dual aged; and
6. Non-dual disabled.

We understand that each of the six models will produce different relative scores for each disease category, reflecting CMS's finding that disease is often treated differently for beneficiaries in different groups. While we have not analyzed relative disease scores within each group, we believe that CMS's finding is consistent with our work and are impressed with the strength of its predictive-ratio analyses. The predictive-ratio analyses show that the new system will be more accurate for beneficiaries in each of the six groups.

### **Conclusion**

The Commission appreciates the opportunity to comment on the important policy proposals crafted by 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.

## **61. Mercy Care Advantage**

Southwest Catholic Health Network Corporation dba Mercy Care Advantage appreciates the opportunity to comment on the proposed changes to the CMS-Hierarchical Condition

-Category (HCC) risk adjustment model for payment year 2017.

Mercy Care Plan (MCP) holds a Medicaid contract with the Arizona Health Care Cost Containment System (AHCCCS) to meet all the health care needs of our members, including acute care and behavioral health, as well as long-term care.

To coordinate care for our Medicaid dual eligible members, MCP also offers a Medicare D-SNP plan; Mercy Care Advantage (MCA). The vast majority of MCA's approximate 17,500 low income dual eligible beneficiaries are "aligned"; receiving all Medicare and Medicaid physical and behavioral health services through MCP/MCA. We believe that the integration of care offers a promising, viable, and efficient way of ensuring that people most in need of deliberative and coordinated care have the critical access to the services they deserve. This leads to better health outcomes and high beneficiary satisfaction for our members. Doing so, however, requires appropriate financing which accounts for the complex needs of the full benefit aged/disabled dual population.

MCP agrees with the comments that AHCCCS and the Arizona Association of Health Plans (AzAHP) have voiced regarding the proposed changes. We believe the net effect of these changes is necessary to financially align the costs of caring for the most vulnerable members of our population, and ensure that covered services are adequately funded.

When the funding is aligned, our members benefit from additional resources and benefits needed to improve their overall health status. Compared to the general Medicare population, dual eligible members have higher social and behavioral health needs.

MCP approves of CMS's research and model development efforts and we believe the proposed changes to the HCC model that include separate community segments will more accurately account for the distinct disease and cost profiles of the various full/partial/non-dual beneficiaries. The result will be higher payments that align with the underlying risk profile of the full dual population that is aged and disabled. This adjustment is needed to keep the D-SNP model financially viable and allow us to continue to serve our members.

MCP is thankful for the opportunity to comment on this important issue prior to the release of the 2017 Advance Notice and sincerely appreciate your reaching out to the stakeholders to share their expertise as CMS considers further enhancements to the risk adjustment model.

## 62. Minnesota Department of Human Services

Minnesota appreciates the opportunity to provide comments in response to the Proposed Changes to the CMS-Hierarchical Condition Category (HCC) risk adjustment model for plan year 2017. CMS' October 28, 2015 memo confirms that the 2014 model in use today significantly under predicts acuity and therefore costs for full-benefit dual eligibles. We strongly supports CMS' intent to revise the structure of the risk adjustment model to address the under prediction.

Since 1997, Minnesota has been operating coordinated Medicare and Medicaid capitated programs for dual eligible seniors. The state has been hailed as a national leader in quality and coordination of care for seniors. Strong, viable Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) partners have been critical to the state's efforts. Our integrated beneficiary materials, integrated benefits determination and appeals process, integrated assessment requirements and many other operational components of our Medicare-Medicaid coordination model relies on the participation of D-SNPs who have agreed to limit enrollment to full-benefit dual eligibles enrolled in a Medicaid managed care plan sponsored by the same organization. Because our D-SNP partners' enrollment is comprised of 100% full-benefit Medicare- Medicaid eligibles, it is critical that they receive appropriate reimbursement to continue to operate.

Due in part to the historical inadequacies of the risk adjustment model, Minnesota has had particular difficulty in partnering with managed care organizations for disabled adults. Therefore, most Medicare and Medicaid eligible disabled adults in our programs remain in uncoordinated Medicaid-only health plans. We are encouraged that the proposed risk model will encourage additional D-SNPs to participate in the integrated program we have created for people with disabilities, supporting enhanced coordination of care for this group. We greatly appreciate CMS's efforts to evaluate the accuracy of the CMS-HCC risk adjustment model for Medicare-Medicaid dual eligibles and to make necessary adjustments.

Minnesota strongly supports CMS' intent to revise the structure of the risk adjustment model to address the under prediction, utilizing the six separate community segments identified in the October 28, 2015 memo. The proposed revisions are a step towards payment equity for plans that exclusively or disproportionately serve dually eligible beneficiaries. These modifications are appropriate and necessary to align incentives for plans to enroll and provide appropriate, high quality services for this complex population. Further, these adjustments ensure the sustainability of state efforts to coordinate care for Medicare and Medicaid- eligible individuals. Minnesota fully affirms this effort to ensure fair payment for dual eligible.

Regarding timelines, we encourage CMS to implement the new model for Medicare-Medicaid plans (MMPs) in 2016 under the financial alignment demonstration, as announced on November 12, 2015. We strongly encourage CMS to extend the revised model to special needs plans outside of the financial alignment demonstration program for the 2017 payment year, or sooner if possible. We believe the revised model will help ensure ongoing and robust participation of D-SNPs. We applaud CMS' stated intention to update the risk adjustment model for all MA plans no later than 2017.

Finally, Minnesota also looks forward to further refinement of the HCC risk model to improve accuracy of costs for certain conditions and subpopulations of dual eligibles, such as people with multiple chronic conditions.

Thank you for your consideration of our comments. We look forward to continuing to work with you to promote integrated care for the Medicare-Medicaid population towards our shared goals of improving their well-being through effective use of resources.

### **63. MMM Holding, Inc.**

I am the Chief Compliance Officer of MMM Healthcare, LLC, PMC Medicare Choice, LLC (the "Plans") and am writing to submit the following comments to CMS with respect to the above-referenced memo regarding Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017. We appreciate CMS' efforts to provide early updates ahead of the Advance Notice.

Please find our commentary below:

1. We believe the proposed approach to revise the CMS-HCC risk adjustment model will better predict costs for beneficiaries based on their dual status and aged/disabled status, making the model more accurate.
2. The proposed revision to identify dual status for full risk beneficiaries in the payment year rather than the base year would make the model more accurate. However, it could add administrative complexities for plans. Please provide further details as to how plans are expected to determine dual status (i.e. whether these are to be collected by plans from local Medicaid sources or will CMS collect and provide); and, since there are often retroactive qualifications, whether there will be lag time built in to ensure the accuracy of the dual status data.
3. While the proposed changes will improve the predictive accuracy of the risk adjustment model, the issue remains that Puerto Rico FFS rates do not account for the absence of dual-eligible beneficiaries in the FFS data. Because FFS data used by CMS to set MA rates for Puerto Rico are not representative of the population to which the rates are being applied, consistent with standard actuarial pricing practices and CMS requirements for pricing MA bids using a manual rate, an adjustment is required to accurately reflect the characteristics of the Puerto Rico Medicare population.

Thank you again for the opportunity to comment on the proposed change to the risk adjustment model announced by CMS for the 2017 contract year. We appreciate the opportunity to comment, express our concerns and provide recommendations. We look forward to continuing to work together to develop sound and sustainable solutions for the unique challenges facing Puerto Rico as a result of the ACA.

### **64. Molina Healthcare, Inc.**

Molina Healthcare, Inc. ("Molina") greatly appreciates this opportunity to comment on the Agency's early update regarding a revised Medicare payment model for 2017.

Molina traces its roots back to 1980 where it started as a single provider-owned clinic in Wilmington, California. We subsequently organized as a health plan, entered direct contracts with the California Medicaid agency, and expanded as a Medicaid health maintenance organization into additional states. Molina started as a D-SNP in 2006, and today serves 41,000 D-SNP members in nine states, eighty-two percent (82%) of whom are full-benefit dual eligibles. Molina started operations as a Medicare-Medicaid Plan (MMP) in early 2014, and today is the largest MMP serving 53,000 members in six states.

Molina believes inadequate funding is a significant threat to the viability of programs that serve dual eligibles, including SNP and MMP. Several neutral observers, including the Medicare Payment Advisory Commission (MEDPAC), have reported that dual eligibles, as a population, have higher incidences of multiple chronic acute medical conditions, functional activity limitations, and behavioral health conditions including substance abuse disorders than the non-dual Medicare population, and these individuals also face challenges associated with social and economic status. Molina's experience supports those findings, and our results demonstrate the current payment model is clearly inadequate to account for the costs associated with these significant and important differences. We expect to experience similar results with MMPs as those plans mature.

We commend CMS staff for your sound analysis and note the conclusions detailed in the early update are largely consistent with work performed earlier by Eric Goetsch of Milliman.

We also thank you for your recent announcement regarding Medicare A/B payment changes that the Agency will be implementing with respect to MMP in January 2016. We appreciate the quick action on this, and believe the changes will help.

With a view toward maximizing the impact of any programmatic changes to address the conclusions reached by CMS, we would like to encourage you to make the changes to the payment model that are described in your early update, and also take the additional steps that are outlined below.

1. Adopt the proposed changes as soon as possible

We hope you will consider implementing these important changes to the SNP payment model before the currently planned PY 2017 as we believe all plans need immediate relief. As an example, we encourage CMS to review the feasibility of implementing a high-level recalibration to D-SNP rates in the final 2015 PY settlement in July 2016.

Further, given the serious shortfalls that plans already have been experiencing with respect to payment for services in both D-SNP and MMP, we ask CMS to make retrospective payment adjustments to reimburse plans for under-payments for their full duals.

2. Add behavioral health factors to the payment model

We recognize this request is outside the scope of this proposal, however, there are currently no rate categories for depression (non-major), anxiety, or many other mental health conditions (e.g., PTSD and personality disorders) that are prevalent in dual eligible populations. Accordingly, we would like to ask CMS to re-evaluate the model to assess the impact of additional mental health conditions, such as non-major depression and anxiety, on predicting the costs associated with providing comprehensive care for dual eligibles, and to add more mental health conditions to the risk-adjustment model to further improve the model's accuracy.

3. Conduct a similar study for Medicare Part D

Since we are in agreement that the Medicare A/B model undercompensates SNPs and MMPs for full duals, we would like CMS to consider whether the same logic can be brought to bear on the Part D payment model. We encourage CMS to undertake a study of the Part D payment model, and make the results public at a future date.

Thank you for the opportunity to comment on these proposed changes. At Molina, our mission continues to be improving the health and well-being of low-income Americans, many of whom are dual eligibles. We believe the proposed changes to the HCC risk adjustment model will positively affect the



lives of Medicare Advantage beneficiaries, especially dual eligibles. Therefore, we strongly urge CMS to adopt the proposed changes to the HCC risk adjustment model at the earliest possible time.

## 65. National Association of Medicaid Directors (NAMD)

The National Association of Medicaid Directors (NAMD) appreciates the opportunity to provide comments in response to the Proposed Changes to the CMS-Hierarchical Condition Category (HCC) risk adjustment model for plan year 2017. Alignment of Medicare and Medicaid payment policies is increasingly important to states' work to drive person-centered systems that address the continuum of complex service needs for the dual eligible population. The accuracy of the risk adjustment mechanism and a meaningful quality rating system – for Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) and Medicare-Medicaid Plans (MMPs) – are essential to the success of this work.

Well over half the states are engaged in work around payment alignment and care integration models using D-SNPs and MMPs. According to NAMD's recently released 4th Annual Operations Survey, 85 percent of responding Medicaid Directors indicated their agency was planning, implementing, or had already implemented Medicaid Managed Long-Term Services and Supports (MLTSS) programs. In addition to the 10 states that have launched a financial

alignment demonstration program with MMPs, over twenty states are in some form of planning or implementation or have already implemented a D-SNP alignment initiative.

We appreciate the rigorous analytical work CMS has undertaken to respond to concerns NAMD and others raised regarding the accuracy of the CMS-HCC risk adjustment model as it relates to predicting the high costs for meeting the complex care needs of the Medicare-Medicaid dual eligible population. In our December 1, 2014, letter to CMS and our March 6, 2015, response to the Medicare Advantage Capitation Rates and 2016 Call Letter, we conveyed our concern that the HCC model does not adequately reimburse for the risk that health plan entities are taking on with the dual eligible population. We remain concerned that the identified inaccuracies in the model pose an immediate threat to the viability of the marketplace. In turn this is undermining the federal and state governments' shared goals around development of value-based care models for the dual eligible population.

CMS' October 28, 2015, memo confirms the 2014 model in use today under predicts acuity and therefore costs for full-benefit dual eligibles in the community. As a result, states are faced with an unstable marketplace as they move towards value-based, person-centered care in Medicaid and particularly for dually eligible individuals.

For this reason we offer the following comments for your consideration.

### **1. NAMD strongly supports CMS' proposal to revise the structure of the risk adjustment model to address the under prediction, including the proposed six tiers.**

We believe the proposal is a step towards payment equity for plans that exclusively or disproportionately serve dually eligible beneficiaries. The current HCC model threatens the viability of such plans, and, in turn, undermines states' initiatives to improve alignment and move towards value-based care models for this complex, costly population.

### **2. We support CMS' proposal to implement the revised HCC risk adjustment model for Medicare-Medicaid plans (MMPs) in 2016. We also support application of the revised model for Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) as soon as practical but no later than 2017.**

We believe the revised model will help ensure ongoing and robust participation of MMPs, Medicare Advantage D-SNPs and Fully Integrated Dual Eligible SNPs (FIDE-SNPs). We encourage CMS to extend the revised model to Medicare Advantage D-SNP and FIDE-SNP plans outside of the financial alignment demonstration program no later than plan year 2017. We acknowledge there are policy and operational issues that must be considered in order to do so. However, addressing the identified under prediction of costs for duals- focused plans is consistent with the transition to value-based care.

**3. NAMD also supports ongoing CMS analysis and refinement of the updated HCC risk model to improve accuracy of costs for certain conditions and subpopulations of the dual eligible population.**

As a first step to improve the accuracy of Medicare’s risk adjustment policy, CMS should apply the revised HCC model in 2016. This update will help provide stability in the market so that states can continue to advance value-based care initiatives that are focused on integrating care for the dual eligible population. Going forward, we encourage CMS to continue to make adjustments to improve the predictive accuracy of the model, for example by conducting further analysis of the plans’ experience with behavioral health conditions and the homeless population.

CMS also requested comments about the application of the model to the Programs for All- Inclusive Care for the Elderly (PACE). If CMS extends the MA payment policies, including the HCC risk adjustment model, to PACE programs, CMS must concurrently extend similar expectations around quality, encounters and other key program and performance components. States are seeking additional information and more dialogue with CMS about the application to PACE, particularly as the PACE demonstration program is launched.

Thank you for your consideration of our comments. We remain committed to working with you to support the ongoing transition to efficient, effective systems that deliver high-value, person- centered care for the Medicare-Medicaid dual eligible population.

## **66. National Coalition on Health Care (NCHC)**

I write to offer the response of the National Coalition on Health Care to the request for public comment on CMS’ October 28th memorandum regarding updates to the CMS-HCC Risk Adjustment Model.

NCHC is the nation’s largest, most broadly representative nonpartisan alliance of organizations focused on health care. The Coalition is committed to advancing—through research and analysis, education, outreach, and informed advocacy— an affordable, high-value health care system for patients and consumers, for employers and other payers, and for taxpayers. Our members and supporters include nearly 90 of America’s largest and leading associations of health care providers; businesses and unions; consumer and patient advocacy groups; pension and health funds; religious denominations; and health plans. Our member organizations represent—as employees, members, congregants, or volunteers— more than 150 million Americans.

Medicare Advantage and Medicare-Medicaid Plans each have the potential to contribute transformative reforms to chronic care—reforms that may ultimately improve care and lower costs in traditional Medicare and system wide. But NCHC believes this potential can only be realized with a risk adjustment system that accurately accounts for the cost of treating all enrollees, especially the most vulnerable.

We commend CMS for its attention this important issue. As CMS’ October 28 memo confirms, at this time, the CMS-HCC model fails to fully account for the impact of fully dually eligible status and disability on plan costs. As a consequence, those who enroll and assume responsibility for the care of these often vulnerable beneficiaries are punished financially, while those who do not are rewarded.

CMS has laid out a thoughtful approach, providing adjustments to the CMS-HCC Model that better reflect the impact of full dual status and disability on plan costs. NCHC believes that CMS should act as soon as feasible to address this problem and that the proposed adjustment outlined in the October 28 memo is a potentially constructive step forward.

At the same time, CMS should press forward with additional efforts to further examine and refine its risk adjustment models. In particular, we urge CMS to immediately undertake analysis to better explain the difference in the impact of the current 2014 HCC model on partial duals relative to full duals. Additionally, we understand that other commenters have requested that CMS promptly clarify whether this proposed adjustment would be budget neutral and thereby avoid reductions in overall payments to MA plans. NCHC supports that request.

## **67. National Committee for Quality Assurance (NCQA)**

Thank you for the opportunity to comment on your proposed changes to the CMS-HCC risk adjustment model for 2017. The National Committee for Quality Assurance (NCQA) strongly supports this effort to better account for the higher costs in caring for beneficiaries who are dually eligible for both Medicare and Medicaid. This is vital for all plans, especially those in the Financial Alignment Initiative that are integrating both Medicare and Medicaid coverage and payment.

Your data-driven approach in proposing payment adjustments based on assessments of the average predicted costs for different subsets of dual eligibles makes sense. Payments that accurately reflect actual care costs for specific categories of lower socioeconomic enrollees will help more plans address related disparities and achieve the high quality care all Medicare enrollees deserve.

Risk adjustment to payments, rather than to performance measures, is the best way to address disparities in care and related average differences in the Medicare Advantage Star Ratings. It is much more constructive than risk adjustment to Star Ratings measures, which would mask disparities without addressing them and lock in lower expectations for those who most need improved quality.

This distinction is critical, as our research shows that some plans do achieve high quality despite having large numbers of lower socioeconomic enrollees. As we noted in our comments on the proposed 2016 Call Letter, some plans with high dual enrollment rates perform well above average on measures for which plans with high dual enrollment on average perform below average. It is imperative that plans have the resources they need to address disparities, rather than dismiss them as something that cannot be helped by risk adjustment to measures themselves.

Thank you for the opportunity to comment.

## **68. National PACE Association**

This constitutes the response of the National PACE Association (NPA) to CMS' request for comment on CMS' October 28, 2015 memo outlining Proposed Changes to the CMS- HCC Risk Adjustment Model for Payment Year 2017. The National PACE Association represents 116 PACE organizations operating 220 PACE centers across 32 states serving over 35,000 individuals. We appreciate CMS' consideration of the following comments and recommendations:

### **Comments**

1) NPA believes that developing risk factors for six distinct subpopulations of Medicare beneficiaries to acknowledge the impact of Medicaid eligibility status, along with institutional vs. community residence, will improve the accuracy of the risk adjustment system. NPA supports the use of the subpopulations'

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distinct risk factors for establishing payments to PACE organizations. NPA notes that approximately 96% of our enrollees are fully dual-eligible for Medicare and Medicaid.

2) In addition to calculating risk factors for the six distinct subpopulations of Medicare beneficiaries, CMS requests comments on changing the current PACE HCC model (HCC v. 21) to the 2014 model being phased in for MA plans (the “2014 model”). NPA, as we have stated previously in response to CMS’ 2013 advance notice of payment when it initially proposed the 2014 model, strongly recommends retaining the current PACE HCC model (HCC v.21) for PACE organizations. Shifting PACE to the 2014 model will reduce the performance of the risk adjustment model for PACE enrollees relative to the model that is currently in place.

The Evaluation of the CMS-HCC Risk Adjustment Model completed for CMS by RTI and released in March, 2011 assessed the predictive ratio of the CMS-HCC risk adjustment model v. 21 relative to an earlier version, v.12. The evaluation found that

v.21 accurately predicts costs for Medicare beneficiaries and, in particular, significantly improved model performance over v.12 for beneficiaries with dementia.

Nearly half (44.8%) of all PACE enrollees have dementia, as of August, 2015. The HCCs (51 and 52) for beneficiaries with dementia that are included in v. 21 and are related to its improved predictive value in comparison to v.12 are not in the 2014 HCC model. Because of the significance of dementia in the PACE enrollee population, we provide detailed comments on this condition and the impact of its removal from the HCC risk adjustment model below.

Further reducing the 2014 HCC model’s accuracy when applied to PACE is its lack of HCCs that support the identification of interactions between early stages of kidney disease and congestive heart failure. Approximately 31% of PACE enrollees have a diagnosis of CHF, and of these 38% are diagnosed with an early stage kidney disease (HCC 138, 139, 140 or 141). We have estimated that the 2014 HCC model would reduce the average HCC score for PACE beneficiaries with congestive heart failure and early stage kidney disease by 20%.

In combination, the 2014 HCC risk adjustment model results in a significant degradation of the CMS-HCC risk adjustment model’s predictive value for the large majority of PACE enrollees.

3) The CMS-HCC risk adjustment model for PACE enrollees needs to include dementia.

Because of the significance of dementia for the cost and care of PACE participants, the CMS-HCC risk adjustment model for PACE needs to include HCCs for dementia diagnoses. As noted earlier, approximately 45% of PACE participants are diagnosed with dementia, as indicated by the percent triggering either HCC51 or HCC52 for dementia in the CMS-HCC risk adjustment model currently applied to PACE (v.21). Removal of dementia related HCCs from the risk adjustment model significantly reduces the predictive ratio of the model for these PACE enrollees and, as a result, will undermine the financial sustainability of PACE programs.

Risk adjustment without HCCs for dementia results in substantial under prediction of the costs of care for enrollees with dementia, who comprise a large proportion of PACE organizations’ total enrollment.

Referring to the Evaluation of the CMS-HCC Risk Adjustment Model that CMS released in March 2011, RTI compared predictive ratios for HCC chronic disease groups and concluded that v.21 of the CMS-HCC model was far superior to v.12 in predicting costs for beneficiaries with dementia. For beneficiaries with dementia, v.21 (with HCCs for dementia) of the model achieved a predictive ratio of 1.000 compared to 0.858 for v.12, which like the 2014 model used for MA plans lacks HCCs for dementia. This indicates that

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predicted costs for beneficiaries with dementia under v.12 are essentially 14% lower than actual costs. Based on historical diagnostic data, NPA's comparison of PACE organizations' mean HCC scores for PACE enrollees with dementia in the v21 model vs. the 2014 model used for MA plans indicates that the 2014 model generates mean HCC scores that are, on average, 21% lower than v.21. We are deeply concerned that exclusion of dementia HCCs in the 2014 model leads to substantial underpayment for PACE enrollees with dementia. These individuals account for almost half of all PACE enrollees.

Failure to recognize dementia related costs is not consistent with CMS efforts to serve more people needing long-term services and supports through health plan options.

As CMS and states seek to enroll more people needing long-term services and supports in managed care options, the impact of under predicting costs associated with dementia will be broader than PACE. While for most Medicare Advantage plans the current prevalence of dementia is low, resulting in a minimal financial loss associated with the removal of dementia as a risk factor, the impact on PACE and other emerging options for people who need long-term services and supports, a large proportion of whom will have dementia, will be much greater.

4) Retaining the current PACE HCC model (v. 21) will reflect the costs of preventing early stage pressure ulcers.

A shift to the 2014 model would eliminate HCCs for pressure ulcers categorized as stage 1 or 2. Without these HCCs, the risk adjustment model would not take into consideration the care planning and treatment required in order to prevent these ulcers from escalating to a stage 3 or 4 ulcer. In the frail population served by PACE, individuals' compromised skin condition along with coexisting medical conditions such as diabetes and peripheral vascular disease often lead to the development of pressure ulcers. The early interventions PACE organizations provide avoid lower stage ulcers from progressing to stage 3 or 4 ulcers. If not prevented, these higher stage ulcers can require high cost procedures, hospitalizations and in some cases may lead to death. The HCC model for PACE should recognize, and incentivize, the investment in prevention made in caring for people with stage 1 and 2 ulcers.

### **Recommendations:**

1. Retain the current v.21 of the CMS-HCC risk adjustment model for PACE

NPA strongly recommends that CMS retain the current v. 21 CMS-HCC risk adjustment model used for PACE payment. This HCC model recognizes the importance of dementia in predicting Medicare costs. In addition, this model appropriately reflects the costs of care for PACE participants with early stage pressure ulcers and early stage kidney disease that is comorbid with congestive heart failure. The combination of PACE county payment rates, the current v. 21 CMS-HCC risk adjustment model and frailty adjustment generates appropriate payment for our high cost population of Medicare beneficiaries.

This assessment is based in part on an analysis, previously shared with CMS by the National PACE Association, undertaken in response to CMS' implementation of the frailty adjustment model applied to PACE beginning in 2008. The study identified a

PACE-like population from among respondents to the National Long Term Care Survey (NLTC) and compares their observed costs in FFS to the costs predicted by the v. 12 CMS-HCC risk adjustment model and revised frailty adjustment model. The study concluded their payments were substantially under predicted. A significant proportion of this under prediction was addressed by implementation of the v. 21 model in CY2012 and further addressed by implementation of the recalibrated frailty adjustment

model in CY2013. Applying the MA 2014 model to PACE will undo the improvements in the risk adjustment methodology for PACE that have been achieved to date.

2. Apply distinct risk factors for the subpopulations of Medicare beneficiaries described in the request for comment to the calculation of payments for PACE organizations.

We concur with CMS that dual-eligible status is a strong determinant of costs to the Medicare program. Establishing distinct risk factors for populations based on this eligibility status, along with institutional vs. community residence status, will improve the accuracy of the payment methodology for PACE.

In addition to the improved performance relative to the MA 2014 CMS-HCC risk adjustment model, retaining the v. 21 model offers the benefit of payment stability for PACE organizations. As comparatively small, not for profit organizations, PACE programs are particularly compromised in their ability to make financial commitments regarding developing and operating PACE by stark annual changes in Medicare's payment methodology.

## **69. Neighborhood Health Plan of Rhode Island**

Neighborhood Health Plan of Rhode Island (Neighborhood) is a non-profit HMO that was founded in 1994 to ensure everyone in the state has access to high-quality, low-cost health care. Neighborhood has been ranked as one of the top Medicaid health plans in America for the past twelve years and currently serves more than 175,000 members. Neighborhood also recently extended its great service, benefits and value to individuals and businesses through HealthSource RI – the state's health insurance exchange.

Neighborhood has recently agreed to participate in our state's Integrated Care Initiative, in partnership with the State of Rhode Island and the Centers for Medicare and Medicaid Services. Once approved, Neighborhood will operate as a Medicare-Medicaid plan, allowing Rhode Island to be the thirteenth (13th) and final state participating in the Financial Alignment Demonstration (FAD). The estimated start date for Neighborhood's MMP is April 1, 2016.

Neighborhood fully supports the positions taken by the Association of Community Affiliated Plans (ACAP) and many other safety net health plans participating in duals demonstration projects, which was communicated to you on November 5, 2015. In this letter, ACAP endorsed the CMS' proposed modifications to the Medicare Advantage (MA) risk adjustment system and proposed additional modifications to further improve the system.

### **Re: Proposed Updates to the CMS-HCC Risk Adjustment Model**

Neighborhood endorses these proposals for the following reasons:

1. Full-benefit dual eligibles are an extremely complex population. CMS' proposed modifications that refine the model segmentation will better predict the cost of providing services to this population.
2. Improving the accuracy of Medicare risk adjustment for full benefit dual eligibles will allow Neighborhood's MMP program to become sustainable more rapidly than predicted in our pricing models. We are encouraged by CMS' November 12th announcement that MMP payments will be better aligned with FFS costs for full benefit dual eligible beneficiaries. Sustainability of our program benefits Neighborhood, CMS and the State of Rhode Island. As noted by ACAP, if MMPs, such as Neighborhood, withdraw from the Medicare program due to payment inadequacy, full benefit dual eligibles can experience a disruption of their continuity of care, and lose access to services and care coordination that are only available to them through integrated care programs.

3. Neighborhood also endorses ACAP's recommendation to further refine risk adjustment modeling to include HCCs related to mental health conditions such as depression, anxiety, PTSD and other mental health conditions. As ACAP indicates, mental health conditions are prevalent in 30-44 percent of dual eligible enrollees and their inclusion would likely dramatically improve the accuracy of the risk adjustment models.

Neighborhood is prepared to support CMS in its efforts to improve risk adjustment programs related to our full benefit dual eligible demonstration project however possible.

## **70. Oregon Health Authority**

The Oregon Health Authority Medicaid program appreciates the opportunity to provide comments in response to the Proposed Changes to the CMS-Hierarchical Condition Category (HCC) risk adjustment model for plan year 2017.

We are supportive of the work that has been undertaken by CMS to address the impact of dual eligible beneficiaries, particularly full-benefit dual eligible beneficiaries, to adjust the payment model for all Medicare Advantage plans, including the Duals Special Needs Plans. We are appreciative of CMS for responsiveness to concerns from across the country to differences in dual eligible populations that impacts Medicare Advantage plans with high dual eligible enrollments, as well as to look at which particular segments of duals might have been most impacted. We encourage CMS to continue to examine the mental health HCCs in the model or pursue other options to address the continued under-prediction for disabled dual eligible beneficiaries.

We are supportive of plans to implement the payment change no later than 2017 and note that if it were possible to engage this payment change in 2016 for all MA plans as is planned for the MMP plans, we would be supportive of that as well.

We believe this change will encourage our Oregon Medicare Advantage plans to continue to be able to offer the lower cost plans to the less attractive and less lucrative full dual eligible market, which is also where we see higher levels of chronic and behavioral health conditions and racial disparities in Oregon compared to our overall Medicaid population. We believe it will also positively impact our PACE program. As we continue to work toward advancing the Oregon Coordinated Care Model, we look to working through our relationships with the Medicare Advantage plans in partnerships to improve health outcomes, improve quality of care and reduce costs for both our dual eligible populations, as well as all of Oregon.

Thank you for the opportunity to provide feedback from Oregon Medicaid.

## **71. PacificSource Health Plans**

Can you please clarify who is a Partial Benefit Dual and who is a Full Benefit Dual?

MEDICAID\_DUAL\_STS\_CD MEDICAID\_DUAL\_STS\_DESC

0 No Medicaid Status

1 Eligible is entitled to Medicare- QMB only

2 Eligible is entitled to Medicare- QMB AND Medicaid coverage

3 Eligible is entitled to Medicare- SLMB only

4 Eligible is entitled to Medicare- SLMB AND Medicaid coverage

6 Eligible is entitled to Medicare - Qualifying individuals

8 Eligible is entitled to Medicare - Other Dual Eligibles (Non QMB, SLMB, QDWI or QI) with Medicaid cove

Based on the memo, I am unclear about what categories “Eligible is entitled to Medicare- Qualifying individuals” and “Eligible is entitled to Medicare- Other Dual Eligibles (Non QMB, SLMB, QDWI or QI) with Medicaid cove” fall under.

## 72. Passport Health

Passport Health Plan thanks you for providing us with an opportunity to comment on the proposed changes to the CMS-HCC risk adjustment model. This proposal was released on October 28, 2015.

Passport Health Plan (Passport) is community-based, nonprofit health plan sponsored by providers that administers Kentucky Medicaid and Medicare D-SNP benefits. Passport provides coverage to more than 270,000 individuals enrolled in Kentucky Medicaid and is also currently enrolling members eligible for Medicare and Medicaid in our Passport Advantage plan. We partner with the state and other entities to improve the health and quality of life of our members. Passport is a proud member of both the Association of Community Affiliated Plans (ACAP) and America’s Health Insurance Plans (AHIP).

**We wish to express our support of the proposal that was put forth by CMS regarding the risk adjustment model as it will improve the overall accuracy of the risk-adjustment model for full-benefit duals.** Specifically, the proposal improves the accuracy for risk-adjustment for some of the more complex populations such as full-benefit aged and disabled duals. It is noted that the proposal recognizes that the risk-adjustment model still under-predicts for *some* disabled duals, and while we agree there is room for improvement in this area, we applaud the efforts put forth in crafting this proposal.

Again, thank you for the opportunity to comment on this important proposed rule.

## 73. PrimeWest Health

PrimeWest Health offers Dual-Eligible Special Needs Plans (D-SNP) to seniors and disabled Medicaid enrollees in 13 rural Minnesota counties. PrimeWest Health supports the research that CMS is conducting regarding the accuracy of the CMS-HCC model introduced in 2014. Refining the model to more accurately account for the differences in cost profiles across the various community segments, as shown by the predictive ratios, will better align total costs and revenues. In addition, the proposed model would make significant improvements at both the high-cost and low-cost extremes thus improving the viability of D-SNPs.

## 74. Puerto Rico Community

We are writing in response to the “Proposed Changes to the CMS-HSS Risk Adjustment Model” for payment year 2017 issued by CMS on October 28, 2015. We acknowledge CMS’ effort to address critical issues related to socio-economic status and current payment methodologies. Moreover, we are appreciative of the additional and particular effort that the CMS leadership has been devoting to the case of over 740,000 Medicare beneficiaries in Puerto Rico. We send our comments looking forward to the execution of legitimate changes in the risk score model as proposed by CMS, while it is still our



urgent concern that we are far from meaningful relief for the citizens enrolled in MA that reside on the island. In the following sections, we briefly review the perspective of the proposed changes within the special context of Puerto Rico, while also proposing a needed adjustment to address potentially harmful unintended consequences created by the unique circumstances of the Medicare program on the island.

**1. We strongly support the implementation of changes to the risk adjustment model in line with CMS' proposal, but we still have a particular crisis for beneficiaries and the MA program in Puerto Rico.**

As stated in the October 28, 2015, CMS Memorandum, and in the 2016 Rate Announcement, the CMS risk score proposal intends to act on "taking very seriously the concerns raised by commenters that the model may disproportionately affect, specific populations, particularly dual eligibles." As noted, there has been a national level concern about the accuracy of the predictability of the 2014 risk score model for low income populations, and the analysis released by CMS validated the need for corrections. The significant underpayment of full benefit dual eligible beneficiaries in MA also confirms one of the critical issues presented by the community of Puerto Rico in the comments to the 2016 Advance Notice back in March 6, 2015.

MA beneficiaries in Puerto Rico are almost 50% full benefit dual eligible. Given the socio-economic context, CMS has noted that the MA program in Puerto Rico would see relatively higher positive impact in CY2017 with the proposed adjustments. Although we recognize this fact, it should also be noted that, in relation to the 2014 risk adjustment model, Puerto Rico is suffering higher year to year payment cuts, as well as higher underpayment in 2016, compared to other areas. This scenario is essentially being validated by the same conclusions that are now legitimately supporting the adjustments for 2017. In accordance to our comments to the CY2016 Advance Notice, actuaries for plans in Puerto Rico estimated that the average payment reduction from 2015 to 2016 (from 33% 2014 Model to 100% 2014 Model) alone generated a blended impact of -5.5% for the 2016 MA program on the island. Moreover, the estimate of cuts were heavily concentrated in the projected payments for the D-SNP plans in Puerto Rico that operate the integrated Medicare Platino program. For D-SNPs, the impact of the risk score model change from 2015 to 2016 was estimated at amounts closer to -8% to -10%.

Notwithstanding this particular scenario, we commend CMS for taking clear steps in the right direction by enhancing the accuracy of the risk score adjustment model considering socio-economic subgroups. Even the precise magnitude of the impact is still not clear, we strongly support the final implementation of adjustments that directionally tackle an observed underpayment for certain low income subgroups, which compose a significant proportion of the MA beneficiaries in Puerto Rico.

**2. Special Circumstances – The Partial Dual segment does not have an identifier in Puerto Rico.**

As explained by CMS, the new proposal would divide the community segment in six different full risk segments. Two of the segments will be defined by the "Partial Dual" aged and disabled population. This population is identified by CMS including the non-full benefit dual Qualified Medicare Beneficiaries (QMBs), the Specified Low Income Medicare Beneficiaries (SLMBs), and other non-full benefit Medicaid categories. The predictive ratios analysis performed by CMS concluded that risk scores for partial benefit duals were over-predicted, similar to those of non-duals, and the proposed model adjustment tested makes a corresponding correction. On the other hand, CMS also determined that full benefit duals have higher costs than partial benefit duals, and partial benefit duals have higher costs than non-duals.

In the case of the Medicare program in Puerto Rico, due to statutory distinctions, the Medicare Savings Programs (MSPs) do not apply. These programs would apply to a significant portion of the Medicare population on the island, given that the full benefit dual category only covers up to 85% Federal Poverty

**Comments on Proposed Changes to the CMS-HCC  
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Level (FPL).<sup>1</sup> The MSPs that provide help to beneficiaries for the payment of part B premium and some of the Medicare FFS cost-sharing, do not exist in Puerto Rico. Accordingly, the system does not have a mechanism to identify Medicare beneficiaries that are partial dual, which would be basically composed of beneficiaries with incomes between 85% FPL and 135% FPL.

Within the context of the current 2014 risk score model, which adjusts risk scores simply based on Medicaid eligibility (full benefit or partial dual), we can conclude that:

The model under-predicted the costs of full benefit duals in Puerto Rico, similar to everywhere else; but in contrast to the scenario in states and DC, in Puerto Rico the model did not over-predict the cost of partial duals because the “partial dual” profile beneficiaries in Puerto Rico were not identified as such. On the contrary, the model under-paid this socio-economic group on the island given they were included in the non-Medicaid (non-dual) category.

Given CMS conclusions, a significant amount of Medicare beneficiaries in the socio-economic group equivalent to the partial dual group are receiving lower risk scores and lower payments than similarly situated individuals in other jurisdictions. As explained below, we are proposing that CMS makes a conforming adjustment under the new six-segment community adjustment model, to avoid a continuing under-payment of the socio-economic group equivalent to partial benefit duals in Puerto Rico.

**3. NEEDED PR Specific Factor, CMS Action Required - Proposed Partial Dual Adjustment to avoid unintended underfunding for low income non-full benefit dual beneficiaries in Territories.**

In order to understand the implication of the lack of MSPs in Puerto Rico, we re-organized the CMS data on Table 2 of the October 28th Memorandum in Table 1 below. We reach to clear conclusions:

For both aged and disabled beneficiaries, costs for partial benefit duals tend to be close to 20% higher than the costs for non-duals.

CMS could calculate the ratio of partial benefit duals to full benefit duals in MA contracts across the nation to make a legitimate estimate about the socio-economically similarly situated beneficiaries for MA contracts in Puerto Rico. The estimated amount of “partial duals” would be significant in Puerto Rico, and the new risk adjustment model can only be appropriately implemented on the island if the implication of the lack of MSPs is addressed.

**Table 1 Estimated Relative Costs for the Six Subgroups (Based on CMS Table 2, Page 4)\***

Segment	Mean Costs	% cost above the base	Exist, but no Indicator for PR	Proportion of Model Sample	Ratio of Partial Benefit Duals to Full Duals
Full benefit dual aged	\$15,147	70%		7.7%	
<b>Partial benefit dual aged</b>	<b>\$10,635</b>	<b>19%</b>	<b>X</b>	<b>3.6%</b>	<b>0.47</b>
Non-dual aged	\$8,932	Base		70.9%	
Full benefit dual disabled	\$10,418	33%		7.4%	
<b>Partial benefit dual disabled</b>	<b>\$9,239</b>	<b>18%</b>	<b>X</b>	<b>2.9%</b>	<b>0.39</b>
Non-dual disabled	\$7,829	Base		7.6%	

\*From Proposed HCC Model changes Memo, October 28, 2015. **100%**

Our proposal is that, in the case of the Non-MSP jurisdictions, for CY2017 CMS should:

<sup>1</sup> Medicaid eligibility 100% FPL is \$11,700 in 2015, while the full benefit dual eligibility in Puerto Rico is at \$10,000, or 85% of the 2015 FPL. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf>

Establish the average risk score factor related to the higher costs of partial duals vs non-duals

Establish an estimated partial dual proportion within the non-dual population in contracts operating in NON-MSP jurisdictions, by using a model based on the contract level ratios of partial duals to full benefit duals in all other jurisdictions (with MSPs).

Applying the partial dual factor to the non-dual segment under the new model, weighted by the projected proportion of partial duals within the non-dual population of each contract.

This proposal would avoid the risk of under-payment for low income population subgroup that would be eligible to the MSPs if available. Consequently, this would also help to mitigate increasing benefit reductions in MAPD products that serve these beneficiaries. In the case of Territories, this adjustment is especially critical given the exclusion of Part D Low Income Subsidy (LIS) benefits for this same segment of the population.

#### **4. Aggravating Factor – Historic lack of access and underreported institutional segment in Puerto Rico.**

As CMS explains, the current risk score adjustment model divides the population in 2 distinct “full risk segments”: institutional and community. The provision of institutional long term care in Puerto Rico is not developed or accessible as elsewhere in the US, mostly as a result of historic statutory and programmatic differences of the Medicaid program. We recognize that to reach clear conclusions and define policy implications related to this factor further analysis and study would be required. However, it is reasonable to assume that the documented institutional population in Puerto Rico is significantly lower relative to states. Still, the disparate accessibility of institutional long term care does not necessarily mean that there is not a subgroup of the Medicare population in Puerto Rico that has a similar risk profile or similar morbidity status as those categorized as “institutional” elsewhere. Moreover, higher costs of the “institutional type” beneficiary in the case of Puerto Rico may be reflected in increased costs for hospital, medical equipment, home care, prescription drug, and other services, rather than costs for long institutional care stays.

By separating these beneficiaries (mostly higher-cost full benefit duals) from the full benefit dual and other segments, CMS appears to be increasing the payment of institutional beneficiaries, in line with the predicted risk. Consequently, in the case of Puerto Rico, there may be a portion of full benefit duals that could merit a higher-payment risk adjustment category, but this population is not clearly or structurally identified given the relatively minimal instances of 90+ day stays. We contend that the risk and costs of this subgroup may have a different form in Puerto Rico, affected by the evolution of a different service model within a system that did not develop institutional long term services as it happened elsewhere in the states. As a result, the full benefit dual adjustment may actually be understated in its application to Puerto Rico. We look forward to discussing this situation with CMS, in consideration of potential particular adjustments that could be merited to address this issue in the future. Notwithstanding, this should be another element noted in the assessment of why unadjusted Medicare policies and formulas may not generate a reasonable result when implemented in the unique program context Puerto Rico.

#### **5. Crucial Context – The general situation of MA in Puerto Rico is still an urgent crisis.**

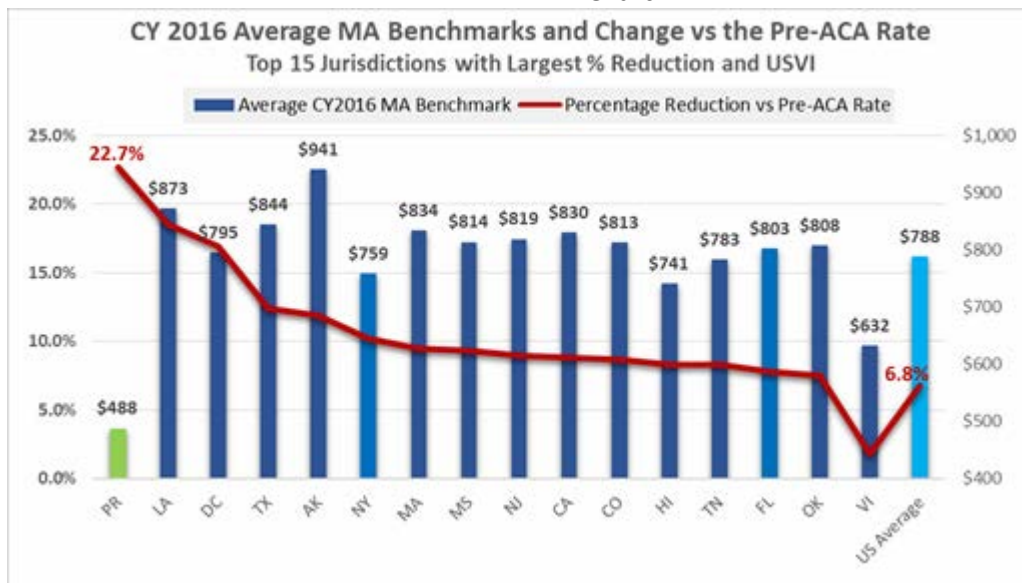
In the full scope of the situation of the MA beneficiaries in Puerto Rico, we should note that the proposed risk score adjustment model changes would be expected to mostly neutralize recent aggravating cuts that disproportionately affected the program on the island in conjunction with the implementation of the 2014 risk score model. The crisis situation of the MA program in Puerto Rico is much broader and deeper, with the MA benchmark average falling by -18% since 2011 and -23% compared to the 2016 Pre-ACA rate. We have explained in detail the particular challenges and risks of

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the Puerto Rico MA program in recent regulatory cycles. Particularly, we expand on MA benchmark, historic FFS data issues and STAR rating program issues in our responses to the CMS STARs RFI (November 2014) and the CY2016 Advance Notice (March 2015). We also stand by our efforts, in recent meetings with CMS, and through the PR Healthcare Crisis Coalition, to emphasize the importance of changing the course of increasing MA benchmark cuts by implementing legitimate administrative action in the CY2017 Advance Notice and Final Rule.

In general, as illustrated in Chart 1, Puerto Rico is still an outlier at the bottom with regards to the MA benchmarks, and the implementation of the ACA has increased the disparity by resulting in the highest reduction compared to pre-ACA rates. We are encouraged by this risk score adjustment proposal by CMS, as well as the recent proposals on the STARs rating methodology. However, a meaningful mitigating action for the particular situation of beneficiaries in Puerto Rico will not be material unless the issues with the MA benchmark are also addressed, in conjunction with the smaller (while truly legitimate and helpful) adjustments in risk scores and STARs methods. The starting point for the MA payments to Puerto Rico for the change from 2016 to 2017 is already an incremental reduction estimated at -6%. This additional cut, is mostly generated by the 6th year of the phase-in period of the new ACA FFS-based formula, in addition to FY2016 reductions in Part A uncompensated care payments made to hospitals in Puerto Rico.

**Chart 1**



**Conclusion**

Finally, we reiterate our support to the CMS proposal for changes to the CMS-HCC risk adjustment model, and strongly request the implementation of our proposal in #3 above, given statutory and programmatic differences in Puerto Rico. Not making a conforming adjustment for the lack of a “partial benefit dual” identifier, would annul the implementation of the proper adjustment for 2 of the 6 segments defined by CMS, largely at the cost of continuing an under-payment and benefit reductions for low income Medicare beneficiaries served by MAPD plans in Puerto Rico.

We look forward to the implementation of changes by CMS, and remain available to discuss an answer any questions about the proposals presented for the particular case of Puerto Rico.

## 75. Rhode Island Executive Office of Health and Human Services

The Rhode Island Executive Office of Health and Human Services (EOHHS) appreciates the opportunity to provide comments in response to CMS' memo, dated October 28, 2015, regarding Proposed changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017.

EOHHS is the umbrella agency in Rhode Island for the following departments: the Department of Health; the Department of Human Services; the Department of Children, Youth and Families; and the Department of Behavioral HealthCare, Developmental Disabilities and Hospitals. EOHHS is also the single state agency for Medicaid. Last year, EOHHS agencies provided direct services to nearly 306,000 Rhode Islanders, as well as an array of regulatory, protective and health promotion services to our communities. Among other initiatives, EOHHS has been working closely with CMS to implement the Financial Alignment Demonstration and establish a capitated Medicare-Medicaid plan to better align the financing and improve the care of people dually eligible for both programs.

EOHHS applauds CMS' efforts to respond to concerns about the accuracy of the CMS-HCC risk adjustment model and to propose changes to address the under-prediction of costs for full-benefit dual-eligibles in the community. We believe that the proposed changes are an important step toward addressing the deficiencies in the risk adjustment model and ensuring the financial viability of plans that serve dual-eligibles in the community. We strongly encourage CMS to implement the proposed changes.

While the proposed changes address some of the most concerning deficiencies with the current methodology, we recommend that CMS continue to refine the model after implementing the proposed changes. For instance, separating community beneficiaries into six subgroups clearly adds predictive value, but this level of stratification could be masking important differences within the population. In fact, CMS analyses indicate that, even with the revised model, there are marked deficiencies, notably for dual-eligibles in the lower deciles of predicted expenditures. Alternatively, in rate setting for the Medicaid program, EOHHS has included groupings based on (a) eligibility for home and community based long-term services and supports, (b) presence of serious mental illness and (c) intellectual and developmental disability to more effectively predict risk. Inclusion of these and other social factors could address some of the continued problems with the risk adjustment methodology and help improve its accuracy.

Thank you for the opportunity to review and comment on the proposed changes to the HCC risk adjustment methodology for dual-eligibles. We appreciate CMS' attention to this critically important issue for Medicare-Medicaid plans participating in the Financial Alignment Demonstration.

## 76. SCAN

SCAN Health Plan (SCAN) is pleased to submit this response to the memorandum from the Centers for Medicare & Medicaid Services (CMS) entitled Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017 ("the memo"), issued on October 28, 2015.

SCAN is a not-for-profit health plan that serves seniors through Medicare Advantage (MA) plans and institutional, chronic care, and dual eligible special needs plans (SNPs). Approximately 170,000 Medicare beneficiaries are enrolled in SCAN's MA plans in California and Arizona, making it the fourth largest not-for-profit MAPD plan in the country. Since 1985, SCAN has specialized in providing comprehensive, high-quality care to the most vulnerable Medicare beneficiaries – those who live with multiple chronic conditions, those who are eligible for nursing home care, and those who experience difficulty performing activities of daily living. Enrollees benefit from SCAN's partnerships with health care

providers that engage with plan members to provide the right care at the right time, while maximizing their ability to maintain their independence. SCAN's comments on the memo reflect this experience.

We applaud the Centers for Medicare & Medicaid Services (CMS) for its ongoing efforts to fully understand and appropriately capture the impact of Medicare's sickest and poorest beneficiaries on plans' risk scores and Star Ratings. We believe that the findings outlined in the latest CMS memo reflect what we have observed as well – that the current CMS-Hierarchical Condition Category (HCC) model under predicts the true costs associated with caring for full dual eligible aged and disabled beneficiaries. We are therefore cautiously optimistic that CMS's proposed updates to the current CMS-HCC model are a promising step in the right direction but, as noted below, would urge CMS to share additional data to facilitate our evaluation of these proposed changes. As we wait for more clarity on whether disease interaction terms will differ by model and on the final relative factors of the revised model to be released next year, we will continue to study the potential interactions and implications of the proposed changes further, but we generally support the direction in which CMS is moving.

### **Proposed Changes to the CMS-HC Risk Adjustment Model**

As set forth in the memo, CMS is planning to propose a revised CMS-HCC model for Payment Year 2017 that would continue to differentiate between the institutional and community population segments. However, the model would include six separate community segments: (1) full benefit dual aged; (2) full benefit dual disabled; (3) partial benefit dual aged; (4) partial benefit dual disabled; (5) non-dual aged; and (6) non-dual disabled. This modification is intended to account for the distinct cost profiles associated with each of these populations and improve the predictive ratios for full benefit and partial benefit dual eligible beneficiaries in the community.

Based on our own data and studies, SCAN has previously expressed concerns to the Agency that the updated CMS-HCC model (the 2014 model) implemented earlier this year in the Final Notice and Call Letter will have a disproportionately negative impact on plans caring for frail seniors, particularly dual eligible seniors with diabetes and heart conditions. Our data indicate that dual eligible beneficiaries with these conditions are likely to also have other conditions, such as heart disease, that are indicative of higher health care costs. The Medicare Payment Advisory Commission (MedPAC) has similarly outlined the challenge that plans face if they have a disproportionately high share of enrollees who have high costs. "Special needs plans (SNPs) and the Program for All Inclusive Care for the Elderly (PACE) are intended to focus on vulnerable, high- cost populations. **Because the CMS-HCC model typically under predicts the cost of the highest cost beneficiaries, these plans can be at a financial disadvantage.**"

Given that the findings outlined in CMS' memo comport with those previously noted by SCAN, MedPAC, and others – specifically that the current CMS-HCC model under predicts the total costs associated with caring for full-benefit dual eligible and disabled beneficiaries – we are cautiously optimistic that the proposed changes to the model will move MA risk adjustment towards more accurate assessments. We believe the demonstrated improvement in predictive ratios across nearly all deciles for each proposed community segment is indicative that the proposed changes would result in more accurate risk adjustments. However, as CMS notes, the Agency is continuing to explore whether disease interaction terms should differ by model segment and is not planning to release the relative factors of the revised model until the 2017 Advance Notice is released. For these reasons, we consider the proposed changes to the CMS-HCC model to be potentially positive.

However, we would urge CMS to provide additional information to industry and stakeholders to help us determine whether the proposed changes to the model will result in an overall reduction in MA plan payments. If that were the case, we would want to work with CMS on developing a solution that is

## **Comments on Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017**

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budget neutral. In recent years, plans have absorbed cuts mandated by the Affordable Care Act (ACA), sequestration, and changes to the 2014 risk model that were implemented in only a few short years. Industry also remains concerned about the impact of ICD-10 and encounter data implementation. In the aggregate, these policies have significantly reduced payments to MA plans, which the industry is continuing to manage while simultaneously working to provide high quality care to a growing number of beneficiaries. Further cuts to the industry should be avoided in order to maintain quality and access.

At the same time, to ensure accuracy through the revised model, we would encourage CMS to consider additional population segments based on frailty (i.e., the number of activities of daily living (ADLs) that a beneficiary struggles with and/or the number of chronic conditions they have). Further, while we appreciate that CMS has acknowledged there is a discrepancy in cost profiles between full and partial dual eligibles, SCAN is concerned that the true costs associated with treating partially-dual individuals may be masked by certain factors attributable to their socioeconomic status. For example, many partial duals do not have the same level of access to health care services that full-duals have. Without full Medicaid benefits, these individuals may not have access to transportation assistance or full financial assistance with direct and indirect costs associated with seeking regular care at a physician's office. Instead, these individuals' care may be obtained only when illnesses have progressed beyond a manageable state and may be sought primarily in emergency departments or other high-cost settings.

Along these lines, we would note that we anticipate the use of in-home assessments to increase dramatically if the proposed changes to the CMS-HCC model are finalized. When used appropriately, in-home assessments allow plans and beneficiaries alike the opportunity to more fully assess the health status of an enrollee. This information allows plans, providers, enrollees, and their families and caregivers to model a plan of care and provide the best individualized resources available to promote the best possible health outcomes. As proposed, the changes to the CMS-HCC model may also offer a new incentive for plans to use such in-home assessments as a mechanism for proactively placing beneficiaries in a community segment for risk adjustment purposes. For this reason, we strongly encourage CMS to provide clear guidelines around in-home assessments and ensure strong, proactive enforcement against the inappropriate use of this valuable tool.

Finally, we support the proposal to have dual status in the community segments be concurrent (i.e., based on the payment year status) under the revised model. We believe that a concurrent approach will provide the most up to date and accurate data, particularly for a frail population, and will better reflect the true costs of providing high quality care to such beneficiaries. We encourage CMS to finalize this proposed approach.

### **Conclusion**

We appreciate your consideration of these comments and recommendations. We applaud CMS' work to date on this important issue, consider the proposed changes to the CMS-HCC Model to be generally positive, but continue to reserve our full support for these updates pending CMS' release of the relative factors of the revised model and other additional information noted above. Until that time, we stand ready to work with CMS as the Agency finalizes its approach and we look forward to our continued work with you on these important issues. Please do not hesitate to reach out at any time if we can provide any additional information.

## 77. Senators Orin Hatch and Ron Wyden

We are writing today in response to the "Proposed Changes to the CMS-HCC Risk Adjustment model for Payment Year 2017" issued by Centers for Medicare & Medicaid Services (CMS) on October 28th. This is an important topic that merits thoughtful feedback.

Unlike traditional Medicare where medical services are paid for on a fee-for-service basis, Medicare Advantage (MA) is paid a monthly, capitated rate, which is based partially on the characteristics of the MA plan's enrollment. Generally, if MA enrollees are expected to cost more than average, payments to the plan are higher. Conversely, if MA enrollees are expected to cost less than average, payments to the plan are lower. Because these payments are made based on characteristics of enrollees and not actual services delivered, it is important that these payments accurately reflect the expected costs of the enrollees.

Today, the current risk-adjustment model provides an increase in a plan's payment if the plan enrolls a dually-eligible beneficiary, commonly referred to as a "dual." However, this adjustment does not distinguish between a "full benefit dual" - a beneficiary who receives medical benefits from both Medicare and Medicaid - and a "partial dual" - a beneficiary who receives only financial assistance from Medicaid to pay Medicare premiums and/or cost-sharing. Under the current model, there has been concern that payments to plans do not account for the significantly higher costs incurred by full benefit duals.

**We support CMS for undergoing a closer analysis of the CMS-Hierarchical Condition Category (HCC) risk adjustment model to determine its accuracy specifically for duals.** This analysis found that while the HCC model as whole accurately predicted costs on average for all beneficiaries, the model results in under payments for duals by over 4%, for full benefit duals by almost 9%, and for full benefit duals over the age of 65 by almost 11%. These inaccuracies hinder the delivery of care for these vulnerable populations and punish MA plans that enroll this population.

**We support efforts to eliminate these inaccuracies and improve the overall accuracy of HCC risk model.** Accurate payment will lead to two significant improvements. Duals will have more robust options to receive coordinated care, and MA plans will be properly incentivized to offer high quality care to the dual population.

Thank you for your attention into this matter. As with any change we encourage CMS to be mindful of the overall impact of this proposed change on access to affordable Medicare Advantage plans. We look forward to working with you to improve risk adjustment in the Medicare Advantage program.

## 78. Senior Whole Health

Thank you for the opportunity to comment on CMS' plan for revising the CMS-HCC risk adjustment model that will be proposed in the Advance Notice for Payment Year 2017. We appreciate CMS' ongoing efforts to continually evaluate the risk adjustment model.

Senior Whole Health (SWH) has operated a FIDE SNP in Massachusetts since CMS' original Medicare/Medicaid demonstrations in 2004 and a FIDE SNP in New York since 2006. We also operate a Medicare Medicaid plan in New York under the current demonstrations.

Senior Whole Health supports CMS' proposal to apply the risk model to six separate community segments in order to more accurately reflect the profiles of members. As the agency's analysis of the



current model shows, the cost to care for our members is under predicted by (8.6%). The proposal will correct this payment disparity between FFS and MA full benefit dual eligibles.

SWH also supports the adjustment to the 2016 payment rates to MMPS as it will improve the financial viability of these initiatives which strive to better align Medicare & Medicaid benefits, improve quality and decrease costs. We believe the proposed model correction should also be applied to full dual plans outside the demonstrations as soon as possible but no later than plan year 2017 in order to correct the identified current under payment for these beneficiaries.

We appreciate CMS' efforts to improve the predictive accuracy of the new enrollee segment of the HCC model. In our over ten years of serving dual eligible individuals we have found that these beneficiaries have pent up healthcare needs that have not been addressed prior to their enrollment in a plan specifically designed for dual eligibles. This has resulted in increased costs during their first year of enrollment. We are concerned that the demographic factors in the HCC model do not fully account for these expected higher healthcare costs in this first year.

Lastly, Senior Whole Health is concerned about the challenges related to the month to month determination of Medicaid eligibility for frail elders. We would advocate for a presumptive eligibility where persons who are over 65, are deemed Medicaid eligible and are receiving long term care services would be exempt from subsequent eligibility determinations. Our experience with these beneficiaries is that it is highly unlikely that their financial status will change so that they will no longer need Medicaid financing. Keeping beneficiaries continuously enrolled allows for continuity of care which we believe is critical to maintain the health status of this population. The monthly redetermination for Medicaid eligibility for this population is excessively costly and administratively complex. We understand such a change would require changes to state Medicaid policies and procedures, however, we recommend that CMS explore options for its implementation SWH appreciates the opportunity to provide CMS with our comments on the proposed risk model. We support the changes and look forward to reviewing and providing additional comments on the Advance Notice.

## **79. SNP Alliance**

The SNP Alliance appreciates the opportunity to comment on CMS' plans for revising the CMS-HCC risk adjustment model to be proposed in the Advanced Rate Notice for Payment Year 2017. We commend CMS for its commitment to evaluating the risk adjustment model in response to concerns that the model disproportionately underpays for the dual eligible population enrolled in Medicare Advantage (MA). We also commend CMS on its unprecedented effort to provide an early release of its findings with an opportunity to comment on plans for a revised model more than three months ahead of the Advance Notice for 2017.

Congress established Special Needs Plans (SNPs) as part of the Medicare Advantage (MA) program in order to improve the quality and cost performance in serving high cost/high need Medicare beneficiaries, including people dually eligible for Medicare and Medicaid. The SNP Alliance is a national organization of 30 health plans dedicated to improving policy and performance of SNPs and Medicare-Medicaid Plans (MMPs) and the lives of the populations they serve. Our members offer 300 public, for-profit, and non-profit plans and serve over one million beneficiaries. Members in the SNP Alliance represent every type of SNP and region of the US. We disproportionately represent plans with the longest history of innovation in integration of Medicare and Medicaid benefits and the largest proportion of beneficiaries with complex medical needs. We work closely with leading State Medicaid

agencies involved in integration efforts and with MMP sponsors across the spectrum of states involved in the capitated Financial Alignment Demonstration.

### **I. Comments on Proposed Segments for the CMS-HCC Risk Adjustment Model**

**The SNP Alliance supports CMS' proposal to apply the risk model to six separate community segments in order to more accurately reflect these subgroups' distinct disease and cost profiles.**

The SNP Alliance fully supports CMS' efforts to evaluate the extent to which the current CMS-HCC risk adjustment model under predicts the cost of providing medical care to dual eligibles enrolled in MA plans, including SNPs. The results of CMS' analysis are alarming: the HCC model under predicts the cost of care for more than 3 million community-based dual-eligible enrollees in the MA program by a wide margin (-4.3%) regardless of plan sponsor.<sup>1</sup> The model's under prediction is even greater for over 2 million community-based full-benefit dual eligible enrollees (-8.6%). Even though the CMS-HCC model can reasonably predict costs for fee-for-service (FFS) beneficiaries overall and at the more granular condition (HCC) level, the study results from CMS are actually being experienced by dual eligible subsets within those cohorts today. CMS' proposal to correct the disparity for dual eligible and disabled subsets is vital to the MA program because under prediction of costs for a broadly defined population in a prospective risk adjustment model leads to systemic under payment for that population across all plans. Moreover, such broad MA under payments create perverse incentives for any health plan under a capitated payment system to avoid enrolling those beneficiaries.

The potential for Medicare to under pay for dual eligibles enrolled in the MA program has long been a concern to the SNP Alliance. We firmly believe specialized managed care is the most appropriate system for this population as their health and socio-demographic profile warrants a focused benefit design and coordinated care approach. In August 2013, the SNP Alliance contracted with Milliman to assess the impact of the 2014 CMS-HCC risk adjustment model on various groups of Medicare beneficiaries served by SNPs. In assessing the accuracy of the 2014 model for populations served by SNPs, Milliman came to the same conclusion as CMS: the current risk model under predicts costs for dual eligibles in MA overall. Consistent with the predictive ratio of .957 reported for duals in Table 1 of the CMS October 28th memo, we found that projected 2016 risk-adjusted MA benchmarks for duals were 3.4% below projected 2016 FFS costs. At the same time projected 2016 risk-adjusted MA benchmarks for non-dual eligibles and the total population were 4.7% and 2.5% above projected 2016 FFS costs for those populations, respectively.

There are four main reasons we support CMS' efforts to correct the current risk model:

1. The proposal improves payment equity between MA and Fee-for-Service (FFS).

CMS' proposed framework would reverse the systematic under prediction of FFS costs that leads to under payment for dual eligible beneficiaries in MA and, in particular, the under payment for full benefit dual eligibles in MA who represent the poorest, sickest, costliest, and most vulnerable subpopulations in our healthcare system.

It is critical that Medicare payments for providing benefits and services in managed care plans are fair and accurate. In recent years, Congress has tied MA payment to Medicare FFS costs at the county level. Yet, CMS' findings reveal that the current community HCC model dampens MA payment across the board for full benefit dual eligible beneficiaries enrolled in MA by 8.6% as reflected in the predictive ratio for dual eligibles of .914 of actual FFS costs. The effect has been to reduce the total amount of medical care resources available in aggregate for full-benefit dual eligible beneficiaries who enroll in MA versus those who remain in FFS. In some areas of the country, the disparity in the risk model is stifling

the ability of MA plans to serve dual eligibles altogether. This disparity is neither fair to over 10 million Medicare low-income beneficiaries who are given the choice to enroll in the MA or traditional FFS program or to the health plans that serve them. Of special concern is the even higher level of disparity between MA and FFS for 8 million full-benefit dual eligibles. CMS' proposal would take great strides to correct the large payment disparities for dual eligible and disabled beneficiaries and more accurately make resources available for these populations when they enroll in managed care.

2. The proposal eliminates perverse financial incentives in Medicare Advantage.

In 1997, CMS established Hierarchical Condition Categories (HCCs) to account for variations in per capita Medicare costs based on health status in making payments to MA plans. A core principle of the HCC risk adjustment system is to mitigate financial incentives for health plans reimbursed under global payment to avoid costly patients with complex needs and enroll only healthy individuals. However, CMS' most recent analysis shows the current CMS-HCC payment method retains incentives to avoid broadly defined populations entitled to Medicare, namely dual eligible and disabled beneficiaries. According to CMS' data, the model under predicts costs of serving dual eligibles in the community by 4.3% and over predicts costs for serving non-dual eligibles by 1.5%. The model under predicts costs for full benefit duals by 8.6% and over predicts costs for partial benefit duals by 8.2%.

We estimate that currently 8% of MA non-SNP enrollment is dual eligible vs the 23% of Medicare FFS enrollment that is dual eligible. The under representation of dual eligible individuals in general MA plans is of concern because enrollment in the MA program overall has nearly doubled as a percent of the Medicare population since risk adjustment was established in 2000. Under representation could stem, however, from a number of factors. One factor could be that dual eligibles do not prefer general MA plans due to the plans' benefit structure. While dual eligibles may not be charged cost sharing if they enroll in general MA plans, benefits often differ from FFS such as covered days in skilled nursing facilities. Another reason may in part be that financial incentives in the CMS-HCC payment methodology have skewed plan enrollment over time.

CMS' proposal would balance financial incentives to enroll vulnerable populations under MA in a manner more consistent with basic principles of risk adjustment than the current model. The proposed changes in the CMS-HCC methodology extend the core principles of risk adjustment from the HCC level to a broad subpopulation level. CMS' analysis suggests MA plans serve six broad, yet distinct populations in the community in terms Medicare costs and HCC patterns:

- Full-benefit dual aged;
- Full-benefit dual disabled;
- Partial-benefit dual aged;
- Partial-benefit dual disabled;
- Non-dual aged;
- Non-dual disabled.

We view these populations as appropriate segments for the CMS-HCC risk model. First, Table 2 of CMS' proposal shows that annual per capita FFS spending for the populations differ by a factor of 2:1, indicating that a single set of HCC coefficients are not sufficient to account for high cost enrollees. Second, Congress and the Medicare program have a long-held heightened concern for dual eligible and disabled groups of individuals as expressed through federal statute and rulemaking. Long-standing

research shows that both the health and socio-demographic characteristics of the dual eligible and disabled populations are worse than their counterparts. Therefore, close attention to the accuracy of Medicare payment to capitated health plans for their care is warranted. Under CMS' proposal, the HCC model would accurately predict FFS costs and more accurately pay for each population segment and for each HCC under each segment. As a result, we believe the proposal would instill appropriate financial incentives for all MA plans to maintain the health and well-being of poor, disabled and aged enrollees.

3. The proposal enables specialized MA plans to survive.

Over 10 million dual eligible Medicare beneficiaries receive benefits and services under both Medicare and the Medicaid program. Using November 2015 enrollment data, programs that **exclusively** serve dual eligible beneficiaries enroll well over 2.1 million of about 3.5 million dual eligibles enrolled in MA. This includes over 1,742,000 persons served by Dual Eligible Special Needs Plans (D-SNPs) and 380,000 dual beneficiaries served by Medicare-Medicaid Plans (MMPs). In addition, we estimate 178,000 dually eligible beneficiaries are enrolled in I-SNPs and C-SNPs (80% of I-SNP and 40% of C-SNP enrollment). Approximately 34,000 duals are served under the PACE program that has a separate payment and risk model from MA.

Congress established specialized managed care programs as a platform for controlling the escalation of chronic care costs and improving related health outcomes for Medicare's most vulnerable, high-cost, high-need beneficiaries. CMS' findings indicate the HCC model under pays MA programs, as they all enroll a high percentage of dual eligibles. Some D-SNPs and MMPs have reluctantly scaled back or closed their offerings for disabled dual-eligible beneficiaries, as the current financial model under MA has not worked for plans to specialize in their care. Others are contemplating closing their doors unless changes are made in the payment methodology to more fully account for costs associated with serving these high-risk/high-need beneficiaries.

For example, Minnesota has operated specialized dual eligible (MSHO) and dual disabled programs (MNDHO/SNP) for over 15 years, which have been very successful at supporting and improving outcomes for these unique populations. Unfortunately, much of the effect of the shortfalls in the current risk model for funding programs focused solely on dual eligible populations has already been experienced. Multiple plans have discontinued one or more of their SNP programs, and it is likely that other plans will either exit the market or greatly modify their product offerings if this issue is not addressed.

As a result, CMS' proposal would improve the financial viability of SNP and MMP specialty care programs to provide enhanced benefits, services, and coordination of care needed by the more than 2.3 million at-risk beneficiaries enrolled.

This enrollment in specialized managed care programs is in addition to approximately 1,165,000 dually eligible beneficiaries currently served by non-SNP MA plans. As a result, managed care programs currently serve approximately 3.5 million dual eligible beneficiaries in total. While the percentage of duals enrolled in non-SNP MA plans is significantly less than the percentage of duals in Medicare FFS, our read of the current enrollment data is that the distribution of dual eligible beneficiaries in MA overall (SNP and non-SNP) is very similar to the distribution of dual eligibles in Medicare FFS overall. This suggests the impact of the proposed risk model would be close to budget neutral for the MA program overall. It also reminds us that to the extent MA plans (SNP and non-SNP) enroll a higher percentage of dual eligibles than in FFS, the financial impact of the CMS proposal would likely be a net positive to MA overall.

4. The proposal takes an important step toward population health management.

As the healthcare system continues to shift incentives from an acute to a chronic care approach to delivering care, MA plans increasingly look to organize care around populations that require a unique array of benefits and services. CMS' payment proposal takes an important step in this direction by providing equitable resources to all MA plans for Medicare's largest clinically vulnerable subgroup — dual eligible beneficiaries. Equitable resources for dual eligibles will better enable plans to advance population-based health management methods for aged, dual eligible, and disabled beneficiaries alike.

We request that CMS clarify the classification for individuals who are disabled. For example, does CMS envision "disabled" to be defined by a person's original reason for entitlement? Or, would the definition of "disabled" include persons who become disabled after aged 65? Also, would persons originally eligible for Medicare because of a disability become part of the aged group after reaching age 65?

## **II. Other Comments**

### **We support the application of the proposal to Medicare-Medicaid Plans in 2016.**

The SNP Alliance fully supports CMS in adjusting 2016 Medicare payment rates to MMPs in order to better align Medicare A/B payments with FFS costs for full benefit dual eligible beneficiaries. This correction is urgently needed because Medicare payment under the demonstration builds in savings relative to FFS costs under each state's initiative. If left uncorrected, the current CMS-HCC model will drastically under pay MMPs below imbedded savings as the predictive ratio alone for full-benefit dual eligibles in the community is .914 of FFS costs. Correcting the CMS-HCC model for full-benefit dual eligibles will improve the financial viability of initiatives like the Financial Alignment Initiative that test ways to align Medicare and Medicaid benefits, and improve cost and quality under both programs.

### **We support the application of the proposal to MA in 2017.**

As with MMPs, we see similar urgency for the proposed model correction in 2016 for plans serving dual eligibles outside of demonstration authority. Some FIDE-SNPs and D-SNPs serve full-benefit dual eligibles on an exclusive basis and in many areas of the country they struggle under MA benchmark rates to afford to offer their plans. Over the last decade, managed care organizations in many areas of the U.S. have reluctantly closed their offerings for disabled dual-eligible beneficiaries or have not contracted with States for disabled dual-eligible beneficiaries, as the current financial model under MA has not worked for plans to specialize in their care — similar to the MMPs. We understand that under CMMI demonstration authority CMS has more latitude to incorporate changes into MMP payment in 2016 compared to MA payment. Therefore, we urge CMS to move forward with the proposed risk model changes for MA plans no later than payment year 2017.

### **We strongly encourage CMS to propose additional refinements to the HCC model.**

The SNP Alliance recognizes that it is not possible in any capitated payment structure to accurately predict costs associated with small subgroups without reverting to concurrent FFS payment. However, the SNP Alliance continues to support additional refinements to the CMS-HCC model that would complement the proposed establishment of separate community segments for the six populations identified. Milliman analysis, for example, found significant underpayments for dual eligibles who suffer from specific chronic conditions. Milliman's study showed that the model under pays plans relative to FFS in 2015 for duals with CHF (-5.9%), CKD (-13.6%), chronic lung failure (-6.8%), physical disabilities (-6.8%), and drug and alcohol abuse disorders (-6.7%). It is also important to note that while most D-SNPs likely serve a cross-section of dual beneficiaries representative of dual eligibles in Medicare FFS, the

proposed model may continue to under predict costs for certain dual eligible subgroups that are the focus of some C-SNPs.

We are particularly concerned about the accuracy of MA payment for Medicare beneficiaries who are homeless. Our experience is that plans serving this population consistently report that homeless beneficiaries are often substantially underserved in Medicare FFS, and as a result, the predicted costs established by the CMS-HCC model are inappropriately low. As a result, plans that serve homeless beneficiaries are severely under compensated for costs incurred during the first year of these beneficiaries' enrollment in the MA program.

We strongly encourage CMS to consider additional changes to the HCCs in the risk model. We believe interaction terms for disability will no longer be needed as three of six proposed segments reflect disability status. However, adding new interaction terms between chronic conditions under all or some of the six proposed segments could be used to more accurately reflect the higher cost of caring for beneficiaries who also suffer with mental illness, substance abuse, specific types of disability (such as physical disability), and other high risk categories (such as persons who are homeless). While the vast majority of chronic conditions are more prevalent among dual eligibles than non-dual eligibles, we expect they represent higher costs of care in both populations. While we recognize that CMS may not be able to address all of the HCC-level recommendations in the forthcoming Advance Notice, we urge consideration of the following HCC changes to further enhance the accuracy within the proposed segments of the risk model:

**Interact more conditions in each of the proposed six segments of the MA risk adjustment model to better reflect cost of patients who have multiple chronic conditions.**

Interact mental illnesses and substance abuse with common chronic conditions, such as Heart Failure, Diabetes, and COPD. These conditions are more prevalent among dual eligibles but they greatly complicate outcomes and the delivery of chronic care for all beneficiaries.

Create common groupings of multiple chronic conditions, such as Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Diabetes. Or, indicate whether a beneficiary has a high number of chronic conditions.

**Add chronic illnesses prevalent among dual eligibles and non-dual eligibles alike to improve clinical scope of the proposed segments of the risk adjustment model.**

**Add indicators of dementia, chronic kidney disease, and diabetic neuropathy as in the CMS- HCC model for PACE.**

**We support CMS in its goals to improve the institutional and new enrollee segments of the HCC model, however we are concerned about the challenges of a month-to-month (concurrent eligible) Medicaid status factor.**

We appreciate CMS' efforts to improve the predictive accuracy of the institutional and new enrollee segments of the model by exploring the use of concurrent (payment year) dual status. Concurrent dual status would eliminate a payment lag for dual eligibles. However, we have several concerns about concurrent status:

The SNP Alliance is very concerned that a month-to-month (concurrent) eligible factor would involve significant costs and excessive operational and administrative burdens for both CMS and plans. It is also not clear to us whether the month-to-month status impacts the accuracy of the model sufficient to warrant the significant costs involved, or the added and administrative complexities.

For frail elders in particular, we would advocate for a presumptive eligibility policy where persons 65 and over who are deemed Medicaid eligible and receiving ongoing long-term care services (in an institution or in the community) would be exempt from subsequent eligibility determinations. We believe it is highly unlikely that frail elderly beneficiaries, once deemed Medicaid eligible, will suddenly generate new additional revenue so that they would no longer need Medicaid financing support. We believe monthly redeterminations of Medicaid eligibility for this population are both excessively costly and administratively complex. It may be that a periodic random audit would be sufficient and more cost effective to identify the potential for aberration in dually eligible beneficiary financing. We understand this policy would require changes in state Medicaid policies and procedures; however, we recommend that CMS explore options for its implementation.

While we appreciate the attention to improving accuracy in the risk model for dual eligibles, we are concerned that the demographic factors that would remain in the HCC methodology do not fully account for expected higher health care costs for newly enrolled dually eligible beneficiaries during the first year of enrollment. This is of particular concern to plans that enroll a higher percentage of dually eligible beneficiaries than what exists in Medicare fee-for-service. This is especially a concern for D-SNPs and MMPs, but it is also a concern for some Community-based I-SNPs and some C-SNPs that serve a high percentage of dually eligible beneficiaries. We would recommend that the new enrollee model be modified to account for differences in costs between full and partial benefit duals.

We would also request that CMS consider paying D-SNPs, MMPs, and other SNPs with a high proportion of homeless persons on a cost basis for homeless beneficiaries served during their first year of enrollment. Plans that serve a high percentage of homeless persons experience significant costs that are not accounted for under the current payment model, given prevailing practices in Medicare fee-for-service. In Medicare FFS, homeless persons receive little medical care in spite of an array of present illnesses, some of which have become serious and chronic through a lack of attention.

**We encourage CMS to share information ASAP regarding proposed HCC coefficients so detailed impacts on individual plans can be known.**

We commend CMS for an unprecedented effort to provide plans and stakeholders with research findings and an opportunity to comment on a proposed revision to the HCC methodology three months in advance of the statutory rate setting process. We believe the level of detail provided in the October 28th memo allows plans to ascertain the general direction of the financial impact of the proposed methodology. However, the HCC coefficients for each segment are needed by all health plans to determine the detailed impact of CMS' proposed changes to their non-institutional, community-based enrollees.

**The SNP Alliance encourages CMS to release the coefficients for the six new community risk models as soon as possible and before the release of the 2017 Advance Notice and Draft Call Letter. To the extent that CMS proposes changes to the institutional and new enrollee models, we strongly encourage CMS to make this information available as well.**

Several SNP Alliance members operate a mix of SNP and non-SNP plans and are highly concerned about a lack of detail regarding how CMS may change other MA payment parameters (such as FFS normalization) in light of the proposed corrections to the risk model. The SNP Alliance agrees that CMS' proposed changes to the risk model will be viewed in light of the full spectrum of changes to be included in the Advance Notice. We urge CMS to be mindful of the impact of all MA payment parameters

combined (county rates, FFS normalization, coding intensity, etc.) as it proposes risk model changes in the Advance Notice.

The SNP Alliance is grateful for the opportunity to provide comments to the early update on the risk model. While we strongly support the proposed changes released so far, our final comments must reflect all the payment changes included in the Advance Notice.

<sup>1</sup>Source: Data contained in CMS' Monthly Contract and Enrollment Summary Report and SNP Data Report for November, 2015 rounded to the nearest 1,000. 1,742,000 (D-SNPs) + 379,000 (MMPs) + 136,000 (40% of 339,010 C-SNP enrollees using MedPAC percentage estimates) + 34,000 (PACE) + 1,165,000 (8% of 14,560,303 non-SNP MA enrollees using MedPAC percentage estimates) = 3,456,000 dual eligibles. Accounting for some percentage of these beneficiaries in institutions, we are estimating that more than 3 million duals in MA, MMPs and PACE are in the community.]

## **80. South Country Health Alliance**

South Country Health Alliance (South Country) appreciates the opportunity to provide comments in response to the Proposed Changes to the CMS-Hierarchical Condition Category (HCC) risk adjustment model for plan year 2017. We commend CMS for its commitment to evaluating the risk adjustment model in response to concerns that the model disproportionately underpays for the dual eligible population enrolled in Medicare Advantage (MA) and we strongly support CMS' intent to revise the structure of the risk adjustment model to address the under prediction.

South Country supports CMS' proposal to apply the risk model to six separate community segments to more accurately reflect these subgroups' distinct disease and cost profiles. South Country commends CMS' efforts to evaluate the extent to which the current CMS-HCC risk adjustment model under predicts the cost of providing medical care to dual eligible enrolled in MA plans, including SNPs. CMS' proposal to correct the disparity for dual eligible and disabled subsets is vital to the MA program since under prediction of costs for a broadly defined population leads to under payment for that population.

CMS' proposal would take great strides to correct the large payment disparities for dual eligible and disabled beneficiaries. It would more accurately make resources available to the populations who represent the poorest, sickest, costliest, and most vulnerable in our healthcare system.

CMS' proposal would improve the financial viability of SNP and MMP specialty care programs to provide enhanced benefits, services, and coordination of care needed by the at-risk beneficiaries enrolled. Long-standing research shows that both the health and socio-demographic characteristics of the dual eligible and disabled populations are worse than their counterparts. Under CMS' proposal, the HCC model would more accurately pay for each population segment and for each HCC under each segment.

CMS' payment proposal takes an important step toward population health management by providing equitable resources to all MA plans for Medicare's largest clinically vulnerable subgroup - dual eligible beneficiaries. Equitable resources for dual eligible will better enable plans to advance population-based health management methods for aged, dual eligible and disabled beneficiaries alike.

As with MMPs, we see similar urgency for the proposed model correction in 2016 for plans serving dual eligible outside of demonstration authority. Some FIDE-SNPs and D-SNPs serve full-benefit dual eligible on an exclusive basis and in many areas of the country they struggle under MA benchmark rates to afford to offer their plans. We strongly encourage CMS to extend the revised model to plans outside of the financial alignment demonstration program for the 2017 payment year or sooner if possible. We believe the revised model will help ensure ongoing and robust participation of D-SNPs. We applaud CMS' stated intention to update the risk adjustment model for all MA plans no later than 2017.



South Country continues to support additional refinements to the CMS-HCC model that would complement the proposed establishment for separate community segments for the six populations identified. We strongly encourage CMS to consider additional changes to the HCCs in the risk model. Adding new interaction terms between chronic conditions under all or some of the six proposed segments could be used to more accurately reflect the higher cost of caring for beneficiaries who also suffer with mental illness, substance abuse, specific types of disability (such as physical disability), and other high risk categories.

While we recognize that CMS may not be able to address all of the HCC-level recommendations in the forthcoming Advance Notice, we urge consideration of the following HCC Changes to further enhance the accuracy within the proposed segments of the risk model:

Interact more conditions in each of the proposed six segments of the MA risk adjustment model to better reflect cost of patients who have multiple chronic conditions.

Add chronic illnesses prevalent among dual eligibles and non-dual eligible alike to improve clinical scope of the proposed segments of the risk adjustment model.

Add indicators of dementia, chronic kidney disease, and diabetic neuropathy as in the CMS-HCC model for PACE.

South Country supports CMS in its goals to improve the institutional and new enrollee segments of the HCC model. We would recommend that the new enrollee model be modified to account for differences in costs between full and partial benefit duals.

## **81. UCare**

UCare appreciates the opportunity to comment on CMS' plans for revising the CMS-HCC risk adjustment model for Payment Year 2017.

### **UCare Strongly Supports CMS' Proposed Plan to Address Risk Model Disparity**

First, UCare is in favor of model revisions that improve model accuracy. We agree the current model under estimates the cost of provisioning healthcare for the most at risk and in need populations.

Second, UCare is encouraged by CMS listening to the needs of plans that serve dual eligible populations. UCare has often commented regarding the shortfall in duals payment, CMS has confirmed our hypothesis through their modeling exercise.

Third, UCare strongly encourages CMS to look at the predictive accuracy for subpopulations of the proposed model under each of the six proposed community segments.

## **82. United Healthcare**

UHC appreciates the opportunity to comment on CMS' proposed changes to the CMS-HCC Risk Adjustment Model for payment year 2017 to account for perceived differences in the accuracy of the model for a variety of cohorts of membership. While UHC agrees with CMS' intent to make the model more predictive, we fear that the proposed solution is too complicated and that inaccuracies in the data used to drive the changes would overwhelm any benefits in improved predictive value. Further, it is difficult to truly understand and evaluate the impact of such changes without having the proposed coefficients for each cohort. Rather than adopt the proposed changes, UHC suggests that CMS publish what the revised risk scores would be under the new model and allow plans to study the proposal beyond the narrow time period between the 2017 Advance and Final Notice so as to provide more

meaningful and substantive comments on the impact of the model to MA beneficiaries. While the stated intent of the CMS proposal is to improve the risk adjustment model for predicting costs of dual eligible beneficiaries, these proposed changes run the risk of inadvertently harming all beneficiaries being served by the Medicare program.

CMS' proposal would increase the number of risk adjustment models from one community model to six community models. UHC is concerned that using six different models will undermine the predictive nature of each model, particularly those with fewer member months. Further, plans will have much more difficulty using six models to predict future risk scores and prepare accurate bids, which may create unnecessary volatility in benefit designs as the forecasting becomes more complex. The CMS proposal does not address other key impacted areas and administrative implementation burdens including changes to plan payment files, including MMR file adjustment, which will also impact any proposed implementation and add to the complexity.

In addition to not having the actual coefficients for the proposed model, plans are currently addressing several other changes that could impact risk adjustment, plan payments and, ultimately, benefits and access to care for beneficiaries. Specifically, plans are currently monitoring the impact of fully moving to the V22 model, transitioning to the ICD-10 diagnoses system, and moving to an encounter data submission (EDS) based diagnosis submission. These changes in conjunction with six new sets of coefficients for community populations will make predicting risk scores and plan payments much more complicated and less reliable. All of these changes could lead to significant variation in payment for certain plans and populations that needs to be understood more closely.

We are also concerned with the proposed change to move from prior year Medicaid status to a concurrent model that varies based on Medicaid status by month, and in particular whether the beneficiary is a full dual or partial dual. Under the current or proposed model, Medicaid status determination is dependent on reporting done by the states and is subject to change from month to month. Often this data is retroactively restated by the state due to reporting latency issues. The changing nature of these data, together with the other changes in risk adjustment data outlined above, would further compound the unpredictable nature of the proposed multiple risk adjustment models.

Finally, as an alternative to CMS' proposal, UHC suggests in lieu of implementation in 2017 that CMS publish a set of risk adjustment coefficients modified by CMS' proposal for plans to study and on which they can comment through 2016. This would reduce the likelihood of unintended beneficiary disruption. At the same time, by waiting a year while considering and before implementing appropriate changes, CMS would allow the impact of the change to EDS and ICD-10 to dissipate. This would additionally allow CMS and the plans to further inform and maximize their analysis using EDS and ICD-10 data.

### **83. University Care Advantage (UCA)**

The University of Arizona Health Plans and University Care Advantage (UCA) Inc. greatly appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) in response to CMS' Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017. UCA was certified on January 29, 2014 by the Arizona Health Care Cost Containment System (AHCCCS - the Arizona Medicaid regulatory agency), per regulatory authority, as a contractor for Medicare purposes in lieu of Arizona Department of Insurance Licensure. UCA, in turn, serves to satisfy the Medicaid contract requirements for The University of Arizona Health Plans-Family Care, Inc. (our Arizona Medicaid health plan) by offering dual eligible members with direct access to a MAPD Dual-Eligible Special Needs Plan.

## Comments on Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017

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UCA applied for and received approval as an MAPD D-SNP for 2015 in Cochise, Gila, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz, Yavapai and Yuma counties. The primary objective of UCA 's Dual Special Needs Plan (D-SNP) is to offer a product that will meet the beneficiaries ' financial and health care needs as well as ensure coordination of care for them. This means:

- Identifying eligible members and their needs,
- Enrolling and retaining sufficient membership of dual eligible beneficiaries to maintain financial viability,
- Provide all dual eligible beneficiaries with the highest level of customer care,
- Actively manage and coordinate care.

Since UCA operates as an integrated DSNP for those members enrolled in both the MA SNP and the Medicaid managed care plan, this allows for better coordination of benefits, payments and care. Just as important, UCA strives to provide beneficiaries and their families with easy-to-understand information, provide trained personnel to answer questions and provide assistance in navigating through the process and ensure that their access to health care through AHCCCS and Medicare is as trouble-free as possible .

In the October 28th memo, CMS confirmed UCA's experience, that the Medicare Advantage (MA) risk-adjustment system under-predicts the costs of full-benefit dual eligibles. CMS also confirmed UCA's experiences that there are cost differences between full-benefit and partial-benefit duals, and between disabled and aged individuals. UCA strongly supports improving the accuracy of Medicare risk-adjustment for full-benefit duals. It is consistent with the fundamental tenant of risk adjustment to adequately fund health plans so that they may provide high quality and cost appropriate health care to members at a level commensurate with their health status.

Given the importance of D-SNP's ability to maintain the financial viability with full-benefit dual eligible, UCA thanks CMS for evaluating and proposing ways to improve risk-adjustment for full-benefit duals. In addition, UCA appreciates the analytic rigor of CMS' analysis and the agency's transparency in sharing the results , particularly the predictive ratios.

UCA believes that CMS' proposal will improve the accuracy of the risk-adjustment model for full-benefit duals. Given the significant credibility of the results of CMS' analysis, UCA asks CMS to implement the proposed changes to the risk-adjustment model for MA plans, including D-SNPs, in 2016. Moreover, the risk-adjustment model's under-prediction of full-benefit dual eligibles has resulted in under-payments to plans for these beneficiaries. We ask CMS to make retrospective payment adjustments for D-SNPs to reimburse plans for these under-payments for their full-benefit dual-eligible enrollees.

We also encourage CMS to continue its analysis of refinements to the institutional model and the new enrollee model. We look forward to seeing the results of those analyses. Further, we ask for more information on the disease interaction terms that CMS is considering should differ by model segment.

Finally, as CMS noted in the October 28th memo, the proposed changes do not fully eliminate the under-prediction for disabled dual-eligible individuals. We suspect the lack of mental health HCCs in the model may explain some of this continued under-prediction. However, there are currently no HCC categories for depression, anxiety, or many other mental health conditions (e.g., PTSD and personality disorders). Given the national focus on the importance of integrated care, especially for members with co-morbid conditions, our health plan has developed specific programs for many of our dual eligible members due to their behavioral health conditions. Currently, forty-five percent (45%) of our UCA members have a diagnosed behavioral health condition. In supporting these members, we have found

through our care coordination activities, including the completion of the Health Risk Assessment, that many of these members with behavioral health conditions are not accessing behavioral health services to improve their symptoms. These undetected and untreated behavioral health conditions have a direct impact on their ability to manage their physical health care conditions. Additionally, our health plan provides high touch case management and outreach to these members to engage them in services and refer them to community services to address their social determinants of health to include lack of housing, natural supports, access to local resources and other services that could support their improved health care outcomes and ultimately reduce health care costs. Our ability to implement this type of intervention is rapidly becoming cost prohibitive due to the current risk- adjustment model. Accordingly, we ask CMS to re-evaluate the model to assess the predictability of additional mental health conditions, such as depression and anxiety, on dual eligibles' costs and to add more mental health HCCs to the risk-adjustment model to further improve the model's accuracy.

UCA is prepared to assist with additional information, if needed.

## **84. UPMC Health Plan, Inc.**

UPMC Health Plan, Inc., UPMC for You, Inc. and the entire UPMC Insurance Services Division (collectively, "UPMC") are pleased to submit the following comments in support of the above-referenced proposed changes to the Centers for Medicare & Medicaid Services-Hierarchical Condition Category (CMS-HCC) risk adjustment model for payment year 2017.

UPMC, through UPMC Health Plan and the integrated companies of the UPMC Insurance Services Division, is proud to offer a full range of commercial, individual, and group health insurance products along with Medicare Advantage (MA), Medicare Special Needs Plans (SNPs), Children's Health Insurance Program (CHIP), Physical and Behavioral Medicaid managed care, employer assistance, and workers' compensation products. UPMC's collective commercial and government program membership exceeds 2.8 million, with a combined 145,000 members in MA and Medicare SNPs alone. Over 20,000 of these Medicare members are enrolled in the UPMC for Life Dual, a 4-Star plan, and the 17th largest dual-eligible SNP in the nation.

We thank CMS (the "Agency") for providing UPMC, other insurance carriers and a wide-range of stakeholders the opportunity to comment on the proposed changes to the CMS-HCC risk adjustment model; changes that will better position SNPs to be in a position to continue to provide high-quality coverage to dual-eligibles. As you know, dual-eligibles are among the most vulnerable of all Medicare beneficiaries and include low-income individuals over 65 and individuals under 65 with severe disabilities. Dual-eligibles are more likely to require long-term care (both institutionally and in community settings), experience poverty and homelessness, and live with chronic, complex and costly health care conditions. The Medicare Payment Advisory Commission estimated that while dual-eligibles make up nearly 20 percent of Medicare enrollment and 14 percent of Medicaid enrollment, they account for nearly 34 percent of total spending in both programs. The Kaiser Family Foundation (KFF)'s analysis of the Medicare Current Beneficiary Survey determined that nearly 40 percent of dual-eligibles are under 65 and, accordingly, qualify for Medicare because of a disability. Only 10 percent of Medicare beneficiaries who are non-duals qualify for Medicare because of a disability. Dual-eligibles are also more likely to have three or more chronic conditions, a cognitive or mental impairment, and live with one or more functional impairments in activities of daily living. Finally, KFF's analysis found that dual-eligibles were more likely to have at least one hospitalization (25 percent versus 16 percent) as well as visit an emergency room (44 percent versus 24 percent) than were their non dual-eligible counterparts.

UPMC is and has long been committed to serving these beneficiaries by offering high-quality, cost-effective SNP products that place a strong emphasis on care management and coordination. As the Agency showed in its analysis set forth in the proposal, SNPs like UPMC often receive inadequate payment rates for the level of complexity and cost of care associated with these efforts. As such, UPMC fully supports the Agency's proposed changes to the CMS-HCC risk adjustment model that will allow for a more accurate prediction of the cost of providing coverage to dual-eligibles. It is with that support in mind that we offer the following comments.

#### **Proposed Additional Community Risk Segment Subgroups**

We appreciate the Agency's evaluation of the CMS-HCC model's ability to predict costs based on a beneficiaries' dual-eligible status, as well as the Agency's subsequent transparency in sharing the results of its analysis. As stated in the Agency's proposal, the analysis indicated that within the institutional risk segment – a predominantly dual-eligible population – the model accurately predicts the cost of coverage for all dual-eligibles, whether partial-benefit or full-benefit. The analysis found however, that within the community risk segment, the 2014 model predicts fairly accurately for non dual-eligibles, over-predicts the actual cost for partial-benefit dual-eligibles and under-predicts the actual cost for full-benefit dual-eligibles. In order to more accurately predict the cost of providing coverage for all beneficiaries in the community, the Agency proposes separate risk segments for six identified subgroups with distinct cost profiles – full-benefit dual aged, full-benefit dual disabled, partial-benefit dual aged, partial-benefit dual disabled, non-dual aged and non-dual disabled. This revised model and the six newly-identified subgroups will reduce the risk that the cost of covering full-benefit dual-eligibles is under-predicted and thus will allow SNPs to receive appropriate compensation for this population. We therefore support the Agency's proposed model changes to the community risk segment.

#### **Proposed Change to Concurrent Dual Status Determination in Community Segment**

We appreciate the Agency's proposal to determine the dual status for full-risk beneficiaries in the payment year. Our experience shows that many Medicare-enrolled individuals are eligible for, but not enrolled in, Medicaid. To increase enrollment in SNPs, plans like UPMC invest heavily in Medicaid enrollment-assistance and in developing clinical programming and benefit designs that are attractive to and best serve the needs of dual-eligible beneficiaries. This investment, outreach and customization is accomplished at a significant cost and with many challenges; the dually-eligible population is often particularly difficult to reach and engage. Therefore, we appreciate the Agency's recognition of this investment and its belief that plans should be accurately and adequately compensated immediately upon Medicaid enrollment, rather than the current practice of delaying such compensation to the start of the calendar year following Medicaid enrollment.

Thank you again for providing UPMC the opportunity to offer input into the proposed changes to the CMS-HCC risk adjustment model for payment year 2017. We look forward to reviewing and offering comments on the relative factors of the revised model in the forthcoming 2017 Advance Notice.

### **85. Viva Health Inc.**

We appreciate the opportunity to comment on the proposed model change and have the following comment:

It seems the primary purpose of your model changes is to address concerns raised by commenters who believe the current risk adjustment model underpays for dual eligibles given the increased focus of some plans on serving duals. If that is the case, we suggest that CMS simplify its proposal by limiting the scope of model changes to focus on dually eligible beneficiaries only. Rather than creating the six subgroups,

we propose that CMS simply raise the base year Medicaid factor by an amount estimated to address the current underpayment on the dual population in aggregate. It is fair to assume plans serving dual eligibles do not target duals who are aged versus disabled or those in partial versus full dual status so a similar overall mix of membership among health plans in these buckets would be expected. This approach addresses the issue of underpayment for dual eligibles without fundamentally altering the risk adjustment methodology which is helpful to plans in forecasting and validating Medicare Advantage premiums.

## **86. Wakely Consulting Group**

CMS stated that the age/sex coefficients wouldn't change from the current. This is puzzling and could have a ripple effect of implications that are not obvious: conceptually it seems like the morbidity component of the overall risk score for non-duals would be (artificially) reduced significantly while the morbidity component for duals would be increased. What are the impacts on MA coding (trend)? It seems like it would dampen MA plans ability to "upcode" non-duals. Does CMS plan to reconsider their proposed MA coding pattern adjustment for this change? Why not just re-calibrate the age/sex coefficients for each of the 6 subgroups? We would like to further explore the statistical soundness of this approach.

Is there still an originally disabled add-on for Aged members?

The following was briefly addressed during the call held on Nov 10, 2015; can you elaborate?

- How does CMS plan to incorporate the necessary data (dual status) in the MMR? What kind of monthly volatility does the dual status have? We already see a significant amount of fluctuation in the Medicaid vs. non-Medicaid status.

## **87. WellCare Health Plans**

WellCare Health Plans (WellCare) is pleased to submit the enclosed comments in response to the Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017, released on October 28, 2015 by the Centers for Medicare & Medicaid Services (CMS).

Nationally, WellCare is one of the country's largest health care companies dedicated solely to serving public program beneficiaries. We currently serve over three million enrollees nationwide, and offer a variety of products including: Prescription Drug, Medicare Advantage, Medicaid, and Children's Health Insurance Program (CHIP) plans; for families, children, and the aged, blind, and disabled. WellCare's mission is to be the leader in government sponsored health care programs in partnership with enrollees, providers, and the government agencies we serve. This mission drives our business and we design our products and support services in accordance with that mission. We have a long-standing commitment to our federal and state partners to deliver value, access, quality, cost savings, and budget predictability. It is from this vantage point that we offer these comments.

WellCare appreciates CMS' ongoing commitment to studying the dual eligible population and the effects the population has on plan payment and the Star Ratings system. We are particularly appreciative of CMS' receptiveness to comments submitted in response to the 2016 Rate Announcement and the Agency's focus on determining the accuracy with which the Medicare Advantage risk adjustment system predicts the cost of caring for dual eligible beneficiaries. In the October 28 memo, CMS confirmed our previously expressed concerns that the 2014 model under-predicts the costs of full benefit dual eligibles.

WellCare supports CMS' proposal to change the structure of the risk adjustment model. Developing a risk adjustment model that includes separate community segments for the specified six populations allows the model to more accurately predict the actual cost of caring for each individual subgroup.

We are, however, concerned that imposing such a significant decrease in the premium for partial benefit dual eligibles could further intensify the acknowledged disparities between plans that serve substantial numbers of low income members and those that serve more affluent populations under the Star Ratings system. These funds are being used to enhance care management and to offer supplemental benefits, such as hearing, vision, dental, and transportation, in an effort to improve quality of care for the beneficiaries. Reducing the reimbursement without providing a meaningful solution to the Star Ratings methodology for the plans serving high proportions of low income members, including partial benefit duals, will only serve to further disadvantage plans serving these beneficiaries under that methodology. Because CMS recognized that the composition of a plan's enrollee population can negatively affect many of the Star Ratings measures, particularly in light of the significant change in funding that this proposal represents for partial benefit duals, WellCare encourages CMS to propose and adopt a solution that adequately addresses the differential challenge.

WellCare asks for clarification on the classification of beneficiaries into the aged or disabled category. Specifically, we ask CMS to explain how it intends to designate individuals who are both aged and disabled.

In the memo, CMS states that there will not be a clinical revision of the hierarchical condition categories (HCCs) for the contemplated model revision. WellCare supports CMS' position. The HCCs used in the risk adjustment model were recently revised for the 2015 plan year. WellCare suggests CMS initially focus on collecting data on the changes to the risk adjustment model to ensure the risk scores ascribed to full benefit duals and partial benefit duals accurately predict their costs. Revising the HCCs in addition to breaking out the populations into subgroups would only add more complexity to the model at this time. Once the model is finalized with the subgroup risk score, WellCare would support CMS revisiting the HCCs, with stakeholder input, to further refine the risk adjustment model. Additionally, in the memo, CMS notes it is exploring whether the disease interaction terms should differ by model segment. WellCare suggests that CMS use the same disease interactions across the seven models, but change the coefficients based on the individual model.

WellCare supports CMS' proposed revision to the model to include dual status in the community segments as concurrent as it allows plans to receive payment for these beneficiaries in advance of the delivery of services. However, WellCare is concerned with the operational feasibility of accurately determining dual status on a month-by-month basis. There are a number of challenges in determining dual status including differences in the individual states' Medicaid qualifications, the ability of processing systems to capture all eligibility categories, and inability for a state and health plan to share data. These issues could lead to inaccurate information upon which dual status is determined, resulting in a delay, denial, or failure of a State to appropriately identify and enroll a beneficiary. WellCare asks CMS to provide details surrounding the data and processes it will use in determining dual status on a monthly basis. If CMS plans to use individual states' data, we suggest CMS propose enhancements to the current reporting systems requiring all states to report a minimum set of data upon which a status determination can be made. In the alternative, we ask CMS to consider a deeming system similar to that of the Extra Help program.

Finally, WellCare understands that, like in previous years, CMS will release the HCC coefficients for each of the seven proposed models in February's Advance Notice with a 14 day comment period. Given the

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significance of the change and the limited time in which to run data, WellCare asks CMS to extend the comment timeframe so as to provide plans with sufficient time to model the proposal. In the alternative, WellCare asks CMS to consider providing the “Risk Adjustment Model Software” SAS code with the Advance Notice. Extending the time frame for comments or providing plans with the code will allow plans to run the numbers, determine the impact, and provide the most meaningful feedback to CMS.

**Conclusion**

WellCare appreciates the opportunity to provide comments on this important policy issue and to partner with CMS as it moves forward in developing and implementing the 2014 HCC Risk Adjustment Model.