BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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March 6, 2009

Abby Block
Director, Center for Drug and Health Plan Choice
The Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Attention: Ms. Deondra Moseley, S2-22-25
By Electronic Mail

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

Dear Ms. Block:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to comment on the Advance Notice of Methodological Changes for Calendar Year (CY) 2010 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies ("Advance Notice"). BCBSA represents the 39 independent Blue Cross and Blue Shield Plans ("Plans") that provide health coverage to more than 102 million – one in three – Americans. The majority of Plans participate in the Medicare Advantage and Part D programs and now serve several million beneficiaries.

We value the long and successful partnerships our Plans have with CMS in Medicare Advantage. Through this program, we have provided valuable benefits, including chronic care management, to Medicare beneficiaries.

As laid out in our detailed attached comments, we are concerned about the impact the proposed changes are likely to have on the 10 million beneficiaries currently enrolled in Medicare Advantage. Our comments raise issues with proposed assumptions and methodologies presented in the Advance Notice and lay out several recommended modifications.

Our Plan actuaries estimate that the cumulative effect of the changes proposed in this notice could reduce current rates by up to five percent. When factoring in expected medical trend of six percent, this could become a payment reduction of up to 11 percent that would result in significant and immediate premium increases and benefit reductions.

The proposed across-the-board cuts would have a devastating impact on all MA beneficiaries, regardless of the type of plan they selected (e.g., HMOs, PPOs, PFFS). These reductions are likely to have the greatest impact on: 1) beneficiaries in rural areas; 2) counties with low Medicare fee-for-service spending where some of the highest quality care is delivered today; and 3) low income beneficiaries who depend on MA for reduced cost sharing and added benefits.

We request that CMS reconsider this proposal in two major areas:

- **Medicare Growth Rate:** We strongly urge CMS to increase the Medicare growth rate estimate to include the projected one percent increase in the Medicare physician fee schedule update as is included in the President's budget. CMS should increase the 2010 trend assumption in the final notice to at least 5 percent, which would be more consistent with expected medical trend in Medicare.

  While we understand that the current physician payment formula would call for a 21 percent reduction in the Medicare physician fee schedule for 2010, it is expected that Congress will act to prevent such a massive cut to physicians before the end of the year – just as they have for much smaller reductions of between 4-11 percent every year since 2003. The assumption that Congress will act to prevent the 21 percent cut is reflected in both the President's budget and the Medicare Trustees Report.

  As discussed in our detailed comments, we understand that CMS has the legal authority and flexibility to include a more realistic estimate of Medicare growth in this instance.

- **Coding Intensity Adjustment:** We strongly urge CMS to reconsider its proposal to apply a negative 3.74 percent coding intensity adjustment to all MA plans and, as an alternative, apply the adjustment only to a defined subset of plans CMS determines to have inaccurate coding (e.g. plans that fail the risk validation audit or plans with risk score increases of two or more standard deviations from the national mean).

  We believe an across-the-board implementation would be in conflict with Congressional intent to adjust payments for "differences resulting from inaccurate coding." An across-the-board application to all plans will have a detrimental impact on the MA plans that are coding accurately and are not seeing the same increase in risk scores as the national average.

  Moreover, we are concerned that this adjustment is being made with the assumption that coding observed in the FFS program is, in fact, accurate. We believe the current risk score validation audit process is the appropriate system to determine coding accuracy and payments should only be adjusted for the subset of plans in which coding problems can be documented.

Thank you for considering our recommended changes. Medicare Advantage enrollees expect stable and predictable premiums and benefits and we believe our recommendations are necessary to avoid potential disruptions to millions of beneficiaries.

The attachment contains our specific comments on Attachments I and II of the Advance Notice.

Thank you very much for the opportunity to provide comment. If you have any questions, please contact Doug Armstrong at (202) 626-4838 or Douglas.Armstrong@bcbsa.com.

Sincerely,

Alissa Fox

Alissa Fox
Senior Vice President
Blue Cross and Blue Shield Association

Specific Comments on Attachment I: Preliminary Estimate of the National Per Capita Growth Percentage for Calendar Year 2010

- ***Issue:*** BCBSA believes that the proposed 2010 trend change of negative 1.1 percent does not reflect the most likely increase in Medicare spending in 2010.

  Recommendation: We strongly urge CMS to increase the Medicare growth rate estimate to include a one percent increase in the Medicare physician fee schedule as is included in the President's proposed budget. CMS should increase the 2010 trend change in the final notice to at least 5 percent to be aligned with historical congressional actions and other CMS estimates of Medicare growth.

  Rationale: We are concerned that the estimate of Medicare growth in the Advance Notice does not track with other estimates of healthcare cost increases. Our actuaries are anticipating an approximate 6 percent increase in medical costs for 2010. On average, over the last decade, Medicare spending has increased 5.8 percent annually. CMS' estimate of negative growth in the Advance Notice is significantly lower than other estimates; including other CMS estimates. For example:

  - In CMS' April 2008 announcement of 2009 MA rates, the agency estimated 2010 Medicare growth to be 3.8 percent even while incorporating an assumed 10.6 percent reduction in the physician fee schedule in July 2008 and additional 5 percent cuts in 2009 and 2010.
  - The 2008 Medicare Trustees Report estimated 2010 per capita Medicare growth to be 4.6 percent, while incorporating "substantially understated" growth as a result of the SGR formula reductions.
  - A February 24, 2009 Health Affairs article, written by CMS actuaries, states that, "Total Medicare spending growth is projected to slow to 2.5 percent in 2010," even with the SGR-mandated 21 percent reduction.

  We understand that there are two major factors contributing to the estimate that per capita Medicare spending will actually decrease in 2010: the scheduled reduction in the physician fee schedule and the economy.

  Physician fee schedule: We are aware that the estimate of Medicare growth includes an assumption that the Medicare physician fee schedule will be reduced under current law by 21 percent in 2010, but historically there has been significant growth in physician spending regardless of fee schedule changes. According to the Government Accountability Office (GAO), Medicare physician spending has far outgrown fee schedule increases. For example, from 2000-2005 the physician fee schedule increased a total of 4.5 percent but Medicare spending for physician services increased by 60 percent and spending per physician increased 41 percent[1].

  While assuming the scheduled 21 percent physician fee reduction will take place is consistent with prior years' rate announcements, we believe CMS has the legal authority and flexibility to estimate Medicare growth that incorporates the same one percent

[1] GAO testimony "Medicare Physician Payments: Trends in Service Utilization, Spending, and Fees Prompt Consideration of Alternative Payment Approaches"; GAO-06-1008T. July 25, 2006

positive update to the physician fee schedule that is included in the President's budget. We believe that there is overwhelming evidence and legal justification for CMS to estimate Medicare growth without the inclusion of the physician fee schedule reduction. Evidence that the 21 percent reduction will not take place includes:

- Congress has enacted legislation every year since 2003 that updates and eliminates the Medicare physician fee schedule reduction and replaces it with a freeze or a positive update.
- The Administration's own proposed HHS budget assumes that this reduction will not take place and includes $13.8 billion in funding in 2010 to ensure it.
- When referring to the projected reduction in physician fees at the time, the 2008 Medicare Trustees Report notes that, "Legislation to prevent or ameliorate such an outcome is highly likely."

Legal review of the Medicare statute and regulations indicate that CMS is not required to include the 2010 scheduled reduction in the physician fee schedule when estimating 2010 Medicare growth rate. In all cases, the Secretary has the authority to make an "estimate", but nowhere in statute or regulation does it say that the Secretary is bound by existing law. If there is a high probability that this law will be changed, the Secretary is not legally compelled to follow this law in developing its estimate. Thus, it is a policy decision on the part of CMS to determine how the estimate is determined.

In the past, CMS has exercised its policy discretion when interpreting how to implement the law when the likelihood of legislation was high. For example, by June 2008, Congress and the President had yet to enact legislation to avert the 10.6 percent physician fee reduction scheduled for July 1, 2008. Because the likelihood of legislation to change the law was high, CMS exercised its authority and made the policy decision to not implement the scheduled reduction on July 1 and instead delayed processing claims until after July 15.

Therefore, due to the very high probability that the law governing the physician fee schedule will be changed, including the one percent positive physician fee schedule update that is in the President's budget would be an accurate estimate of Medicare growth in 2010. CMS is not legally compelled to include the current-law scheduled 21 percent reduction when making its "estimate" of Medicare growth for 2010.

Economy: We are also very concerned that CMS has made assumptions about the economy's effect on Medicare spending (mentioned on a CMS conference call February 27, 2009) but has not provided any data or explanation as to how they arrived at their undisclosed conclusion. We do not believe that the slowing economy will result in reduced utilization of medical services for the Medicare population.

The utilization of medical care for the under-65 population is correlated with insurance coverage provided through the employer-based system and when people lose their jobs and health insurance coverage they tend to use fewer services. But this paradigm is not applicable to the Medicare population as Medicare beneficiaries do not lose their Medicare coverage. And even though Medicare does have relative high cost sharing and no out-of-pocket caps found in many MA plans, the cost-sharing under Medicare is significantly lower than that borne by self-pay individuals.

Even though the economic downturn is over a year old, our Medicare actuaries have seen no decrease in service utilization under Medigap. It is unreasonable to assume that the slowing economy will have any material effect on the utilization of medical services in Medicare.

Specific Comments on Attachment II: Changes in the Payment Methodology for Original Medicare Benefits for CY 2010

- ***Issue:*** BCBSA has significant concerns with the proposed across-the-board application of the new coding intensity adjustment.

  Recommendation: We strongly urge CMS to reconsider its proposal to apply a minus 3.74 percent coding intensity adjustment to all plans and instead apply the adjustment only to a subset of plans (e.g. plans that fail a risk validation audit or plans with risk score increases two or more standard deviations from the national mean).

  Rationale: We have fundamental concerns the proposed methodology to apply the coding intensity adjustment for the following reasons:

  1) *"Inaccurate" coding:* The conference report to the Deficit Reduction Act (DRA) specifically states that the coding intensity adjustment was designed "for differences in coding patterns made for differences resulting from inaccurate coding."

     In comparing the coding patterns between MA and FFS, CMS has determined that risk scores are increasing twice as fast in MA. But CMS has not disclosed their analysis to determine that coding in the FFS program is the accurate and appropriate benchmark against which to compare MA. In reality, CMS has also determined coding increases in the FFS program and has already applied a negative fee-for-service normalization factor to account for those increases in coding. At a minimum, these two factors should be subtractive, not additive, or plans will be penalized twice for coding practices observed in the FFS program.

     Increases in risk scores do not represent an indication of inaccurate coding. We are very concerned that the across-the-board adjustment, proposed by CMS, benchmarks MA against the FFS program and penalizes all plans without any consideration of the accuracy of coding when matched against specific plan membership. Moreover, the proposed adjustment penalizes all plan types uniformly regardless of efficiency, enrollment, geographic region or urban/rural location.

     As MA payments have transitioned to a fully risk-adjusted system, MA plans are now paid based on the accuracy of the coded health status of their enrollees. MA plans are paid more for sicker enrollees than healthier enrollees. In order to increase the accuracy of payment and comply with CMS regulations and guidance, MA plans have invested resources to improve data collection and educate providers on the proper documentation of DRG diagnosis codes in addition to CPT codes. An across-the-board coding intensity adjustment would penalize many plans for doing what CMS and Congress intended when they implemented risk-adjusted payments.

The risk score validation audit process currently being implemented by CMS is the appropriate vehicle to determine accuracy of coding. Through this audit process, plans submit documentation from provider records of plan enrollees to determine coding accuracy. If inaccuracies are determined, plan payments will be adjusted accordingly. The audit process coupled with an across-the-board reduction to all plan payments in 2010 is inappropriate.

The proposed methodology for the adjustment does not define inaccurate coding and does not adjust for inaccuracies. Instead, the proposed methodology uses a blunt instrument to penalize all plans for what is undoubtedly the behavior of a select subset. In the absence of specific findings of inaccurate coding, the rate at which a plan achieves its risk score level may not be relevant. Therefore, we believe that it is not in keeping with Congressional intent for CMS to make a negative adjustment to all plans regardless of whether improper or inaccurate coding has been identified.

2) *Scope of adjustment:* We are very concerned that this negative 3.74 percent adjustment could affect all plans and all MA enrollees – in addition to the negative 4.1 percent fee-for-service normalization adjustment.

We believe the proposed adjustment should, at a maximum, be applied only to the subset of plans that CMS has identified as inaccurately coding. CMS' study methodology identified an approximate two percent increase in coding per year on average. Therefore, some plans must have had higher than average increases while others have lower than average or no increase at all. CMS should identify plans to audit, such as those with significantly higher than average coding increases (i.e. two or three standard deviations from the mean) and only adjust payments for the subset of plans in which coding problems exist.

In addition, the adjustment must have an appeal process with possible nullification if the plan's coding proves to be correct and reliable when matched to their specific membership. As proposed, the adjustment is an across-the-board downward adjustment to all plans with no process for appeal and validation and penalizes all plans' 2010 payments because of the past coding increases of a subset of plans without regard to coding accuracy.

3) *Stayer cohort problems:* We are concerned that the study methodology, which uses 2-year "stayer" cohorts (i.e. 2004-2005, 2005-2006, 2006-2007, and 2007-2008) may overestimate the increase in MA coding. Medicare Advantage plans enroll beneficiaries in the first year and spend the subsequent year educating providers and gathering diagnosis data in order to provide accurate coding and payment in the second year of enrollment. Furthermore, with the rapid increase in MA enrollment since 2004, using a 2-year stayer cohort captures a large proportion of MA stayers that are new to MA with no coding history in year-one with potentially larger coding increases in the second year as the plan gains accurate diagnosis data.

We recommend that CMS study 3- and 4-year stayer cohorts prior to making any adjustment in order to determine a more accurate determination of the differences in

coding increases between MA and FFS. We also recommend CMS study the cohort of individuals that would not qualify as stayers due to being in MA or FFS for only a single year over the examined time period. The reasons why individuals might leave MA or leave FFS Medicare for only a single year may have a contributing factor to the change in average program risk score not accounted for by using 2-year stayer cohorts.

While we appreciate CMS soliciting comments on whether it should use alternative approaches with greater of smaller numbers of years for 2010, we do not believe that either the CMS or plans have the requisite data to provide meaningful feedback. We believe CMS must complete an analysis and present results prior to soliciting comments and making any such adjustment.

4) *Geographic scope:* We recommend that CMS study the coding patterns between FFS and MA at more local levels, such as state or county, rather than a national average. It is well documented that health care delivery is subject to local practice patterns and health status may also vary by geographic areas[2]. Making a nation-wide adjustment to all MA plans due to coding practices, without any acknowledgement of local FFS practices, could penalize plans in areas of the where local FFS coding increases outpace the national average increase.

5) *Lack of appeal mechanism:* As suggested above, we recommend that any adjustment made solely on a plan's coding patterns compared to a national average, must provide an appeal mechanism. Plans must have the ability to demonstrate that their coding patterns are correct.

6) *Lack of phase-in:* Consistent with a broad range of CMS precedents, we recommend that any new adjustment made to MA plan payments be phased-in. CMS frequently approaches changes in payments by phasing-in or –out certain methodologies (e.g. budget neutrality, risk adjustment, frailty factors, Part D LIS benchmarks and risk corridors). Any negative adjustment of this magnitude affecting millions of beneficiaries should be phased-in over multiple years in order to reduce beneficiary disruption.

- ***Issue:*** We believe that the negative 4.1 percent fee-for-service normalization factor is unnecessary.

  Recommendation: CMS should reduce the fee-for-service normalization factor to the 2008 level and continue to reduce this factor until budget neutrality is fully phased-out, when the factor should be eliminated.

  Rationale: Although the Deficit Reduction Act of 2005 (DRA) legislated inclusion of the fee-for-service normalization adjustment, continuing high negative adjustments will negatively impact MA payments as budget neutral risk-adjustment is phased-out. According to CMS' 2004 rate announcement, the first year of implementation of this adjustment, "While [fee-for-service normalization] is an annual adjustment, it does not

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[2] See: Fisher, Elliott, M.D., Bynum, Julie, M.D. and Jonathan Skinner, Ph.D., "The Policy Implications of Variations in Medicare Spending Growth." The Dartmouth Institute for Health Policy and Clinical Practice

negatively impact payment to M+C organizations as long as risk adjustment is implemented in a budget neutral manner."[3] This indicates that plan payments *will* be negatively impacted as budget neutral risk adjustment is phased-out and the fee-for-service normalization factor is retained.

- ***Issue:*** The preliminary estimate of the prescription drug fee-for-service normalization factor in the Advance Notice is substantially increased to 1.146 up from 1.085 in 2009.

  Recommendation: We recommend CMS phase-in the Part D normalization factor consistent with other changes in payment methodologies.

  Rationale: For calendar year 2010, CMS will be calculating the Part D normalization factor differently than in previous years. For the first time, CMS will be normalizing based on Part D enrollees compared to Part D eligibles. This new methodology has resulted in a step spike in the negative normalization factor from 8.5 percent in 2009 to 14.6 percent in 2010. Consistent with other substantial changes in payment methodology (e.g. budget neutrality, risk adjustment, frailty factors, Part D LIS benchmarks and risk corridors) this adjustment should be phased-in over multiple years in order to reduce beneficiary disruption.

- ***Issue:*** CMS has decided not to incorporate the cost of care received by Medicare beneficiaries at Veterans Affairs and Department of Defense (VA/DoD) facilities when calculating MA benchmarks.

  Recommendation: CMS should include the cost of care received at VA/DoD healthcare facilities in the calculation of MA benchmarks as required by law.

  Rationale: By excluding the cost of care received at VA and DoD facilities, CMS is underestimating FFS spending which inappropriately reduces MA benchmarks. Geographic areas with higher numbers and concentrations of VA/DoD facilities will be impacted the hardest by excluding these costs. Congress required CMS to incorporate these costs for years beginning in 2004 and CMS has yet to implement this factor.

  In the Advance Notice to CY 2009 rates, CMS proposed an option to include VA/DoD costs in the calculation of MA benchmarks. Although the proposed methodology presented some problems, we encourage CMS to continue to explore alternative ways to collect the necessary data to incorporate this required adjustment.

- ***Issue:*** In 2010, CMS will transition to a new Medicare Secondary Payer (MSP) process for MSP payment adjustments that will no longer require Plans to survey their enrollees on their MSP status. In the replacement process, CMS provides data that would need enrollee verification and subsequent submission of plan survey data.

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[3] Centers for Medicare and Medicaid Services, "Announcement of Calendar Year (CY) 2004 Meidcare+Choice Payment Rates". May 12, 2003. p. 24

Recommendation: CMS should allow Plans to survey their members with CMS identified data but also be able to submit data to CMS for beneficiaries not captured in the CMS database.

Rationale: There is a lack of complete confidence in the CMS data at this point because of new data submissions resulting form implementation of Section 111 of MMSEA. Plans would prefer to still be able to add data as needed from their own surveys and not relay solely on CMS provided data.

- ***Issue:*** The Spring 2009 software release by CMS changed the submission process of MSP data which will require system updates and IT coding changes, which will be obsolete in less than a year.

  Recommendation: CMS should revert to the process in place prior to the Spring 2009 software release for submission of MSP data in 2009.

  Rationale: It in not necessary for plans to expend significant resources to update their IT coding systems in 2009 if they will be obsolete in under a year. CMS indicates that, beginning in payment year 2010, CMS will no longer require that MA organizations conduct, nor will it use the results of, the plans MSP survey results to determine a member's primary or secondary status.