MEDPAC Medicare Payment Advisory Commission

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January 6, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4144–P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: File code CMS–4144–P

Dear Dr. Berwick:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule entitled Medicare Program; Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Proposed Changes, published in the *Federal Register*, vol. 75, no. 224, pages 71190 to 71292. This proposed rule implements provisions of the Patient Protection and Affordable Care Act (PPACA) and makes other changes to the Part C and Part D programs. We appreciate your staff's ongoing efforts to administer and improve the Medicare Advantage (MA) program, particularly considering the agency's competing demands. Our comments below deal with two aspects of the MA program discussed in the proposed rule, benefit design and quality.

The proposed rule has two provisions regarding policies on cost sharing and benefit design that are of concern to the Commission. The first is the proposal to prohibit MA plans from imposing any cost sharing on home health services. The second is the proposal to prohibit any use of tiered cost sharing for Medicare Part A and Part B benefits. As we explain in more detail below, we believe that each of these policies limits the flexibility of plans to design benefit structures that can promote efficient and effective care. In the case of home health care, the Medicare benefit is not a well-defined benefit. Care in the home can be an effective alternative to care in other settings if the benefit is structured properly, but the ambiguities surrounding coverage of home health care in Medicare make cost sharing a useful tool for health plans to have available as a means of ensuring appropriate and effective use of the benefit. Concern over the appropriate and effective use of the benefit has in fact led the Commission to begin considering a recommendation to introduce cost sharing for home health in fee-for-service (FFS) Medicare.

We are also concerned about the quality bonus program that will be implemented for the entire

MA program through demonstration authority. The Commission has a long-standing recommendation that demonstration authority should be used only to test smaller-scale innovations rather than to implement large programs that significantly increase costs for the Medicare program. We also have concerns about the star rating system that CMS will use to determine plan bonuses. We state our specific concerns below.

Benefit design and cost sharing rules: Prohibiting home health care cost sharing (proposed 42 CFR § 422.262(c)(1)(2))

PPACA added statutory requirements to address a practice among some MA plans of imposing cost sharing above Medicare levels in a way that could be discriminatory or possibly intended to avoid higher-risk individuals—for example, imposing coinsurance on chemotherapy drugs of 30 percent when Medicare FFS coinsurance is at 20 percent for such drugs under Part B. There are three new provisions in PPACA that deal with permissible levels of MA cost sharing:

1. For certain specified services, plans cannot impose cost sharing above Medicare FFS levels (the specified services are skilled nursing facility care, chemotherapy administration, and renal dialysis services);

2. The Secretary has authority to expand the list for which cost sharing cannot exceed Medicare FFS levels; and

3. Plans are expressly permitted to impose cost sharing on services for which Medicare FFS has no cost sharing.

The proposed rule implements the new statutory provisions.[1] For Medicare-covered home health care, CMS proposes to prohibit any cost sharing.

The new statutory provision specifically allowing cost sharing on services for which Medicare FFS has no cost sharing would appear to be aimed at the two major service categories in Medicare that have no cost sharing, laboratory services and home health care. The proposed home health cost sharing rule is based on the authority, under section 1857(e)(1) of the Social Security Act, to include in MA contracts "such other terms and conditions not inconsistent with this part…as the Secretary may find necessary and appropriate."

The rationale stated in the proposed rule for prohibiting home health cost sharing is that plans will "continue to have adequate flexibility to design plan benefits that are responsive to beneficiary needs and preferences while providing access to high quality and affordable health care" (p. 71198 of the proposed rule), and plans "should be able to adequately manage the use of home health services absent enrollee cost sharing" (p. 71255). However, CMS is inconsistent in its rules governing MA plans' ability to impose cost sharing for post-acute care. We note that the agency specifically allows MA plans to impose cost sharing for the first 20 days of a covered skilled

[1] Some of the PPACA provisions have already been put in place for the 2011 contract year through a program memorandum issued on April 16, 2010 (*Policy and Operations Guidance Regarding Bid Submissions; Duplicative and Low Enrollment Plans; Cost Sharing Standards; General Benefits Policy Issues; and Plan Benefits Package*

nursing facility stay, despite there being no cost sharing for such care under traditional FFS.

In light of the rationale given for prohibiting home health cost sharing, it could be argued that MA plans may have fewer tools available to ensure appropriate utilization of home health care than SNF care. Admission to a SNF is very much under the control of the health plan, and the care is more likely to be monitored more closely on a day-to-day basis than home health care. Home health care is a less well-defined benefit in Medicare and its appropriate use is more difficult monitor.

In summary, we believe that the proposed prohibition on MA cost sharing for home health care is unduly restrictive and based on a weak rationale. If the rationale is that plans have many tools for ensuring appropriate utilization, we would argue that cost sharing should be one of the tools that plans can use at their discretion in the case of home health care as a means of ensuring appropriate utilization.

If there is a concern about home health cost sharing being discriminatory or acting as a barrier to necessary care, CMS can evaluate plan proposals for home health cost sharing, in the same way that CMS has evaluated specific cost sharing proposals in the past and will continue to do so, to prevent discriminatory or excessive cost sharing. The Commission is currently considering these kinds of issues as part of our deliberations on whether or not traditional FFS should have cost sharing for home health services, the level of such cost sharing, and the circumstances in which the cost sharing would apply.

Benefit design and cost sharing rules: Prohibiting tiered cost sharing for medical services (proposed 42 CFR § 422.262(c)(1)(2))

The proposed rule prohibits tiered cost sharing of any kind as of the 2012 contract year. The proposed regulatory language would provide that MA cost sharing "cannot vary across enrollees of a plan for any reason, including that based upon primary care provider group, specialist, hospital network or an enrollee's utilization of health care services."[2] CMS is proposing this change because the agency is concerned that "an increasing number of plans are charging beneficiaries different amounts of cost sharing for services depending on, for example, which provider group the beneficiary selects, the plan's network of hospitals, or how frequently the beneficiary uses selected services." The proposed rule notes that "Program experience has demonstrated that differential, or 'tiered,' cost sharing is simply not transparent and can be deceptive and misleading in terms of the

[2] The statute does not specifically prohibit variation in cost sharing in MA. The statutory basis cited in the proposed rule for prohibiting tiered cost sharing is section 1854(c) of the Act, requiring a uniform premium and bid. The current regulatory language at 42 CFR § 422.262(c)(1) provides that premiums and bids "may not vary among individuals enrolled in an MA plan," adding that an MA organization "cannot vary the level of cost-sharing charged for basic benefits or supplemental benefits (if any) among individuals enrolled in an MA plan (or segment of the plan)." The uniform cost sharing requirement was added to the regulations in 1998, and it was noted that "While cost-sharing amounts are not expressly mentioned" in the statutory provision requiring a uniform premium, CMS would use the authority it has to establish plan standards (section 1856(b)(1) of the Act) as the basis for not allowing organizations to vary "the level of copayments, coinsurance, or deductibles charged for basic benefits or deductibles charged for basic benefits or supplemental benefits among individuals enrolled in" a plan (*Federal Register*, June 26, 1998 (Volume 63, Number 123), p. 35008).

cost to beneficiaries," and that cost sharing can be a barrier to obtaining needed care or could otherwise have an adverse impact on sicker enrollees.

While we share the concern over differential cost sharing if it is applied to a beneficiary's frequency of use of a service or services, or if it causes sicker beneficiaries not to seek necessary care, we believe that CMS should be open to cost sharing structures that can help plans be more effective and efficient in their provision of care. The Commission often describes the MA program as a laboratory in which plans' innovative practices—including innovations in benefit design—can be implemented in the Medicare program overall if those practices are successful and beneficial. In the private sector, health plans are experimenting with alternative cost sharing structures that promote better access to care for sicker beneficiaries and better compliance with treatment regimens—for example, by waiving copayments for certain services provided to diabetics. Plans can also provide incentives to have patients use higher-quality, more efficient providers. By having some flexibility on cost sharing rules, MA plans would be allowed to test such innovations for a population with characteristics and needs that are different from the commercially insured population.

With regard to the question of whether tiering is transparent to beneficiaries, tiering, or variations in cost sharing, are found throughout the Medicare FFS and MA programs: in the tiering of cost sharing for drugs in Part D, for example; in the differential cost sharing that is the defining feature of PPO plans in MA; and in the FFS cost sharing differences for participating versus non-participating physicians. Tiering can be transparent for beneficiaries if the differences are explained well and if the tiering has a reasonable, understandable basis.

CMS should be open to alternative designs for cost sharing that can improve beneficiaries' care and which may be models for changes in the FFS program. There should not be a blanket prohibition on tiered cost sharing, but instead CMS should evaluate reasonable proposals by plans to use such programs.

Quality measurement and the quality bonus payment demonstration project

We commend CMS for its thoughtful discussion of the direction the Medicare program should take in measuring and improving health care quality. Much of the discussion in the proposed rule regarding MA quality goals parallels the discussion and recommendations in the Commission's report to the Congress published in March of 2010 (the report requested by the Congress in section 168 of the Medicare Improvements for Patients and Providers Act of 2008).[3] In particular, we note CMS's stated desire to move towards more outcomes-oriented measures and to expand the number of measures targeted towards Medicare beneficiaries and specific classes of beneficiaries, such as the frail elderly. We also agree with the emphasis placed on improvement and the Agency's stated intention of emphasizing demonstrable improvements and continually raising performance targets to promote continual improvement. We would urge CMS to aim towards the earliest feasible implementation of improvements in quality measurement and reporting.

[3] Medicare Payment Advisory Commission. 2010. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

We have several concerns, however, about the MA quality bonus payment (QBP) demonstration project that CMS announced simultaneously with the release of the proposed rule. Although CMS has not solicited public comment on the demonstration, our concerns are significant enough to bring to the agency's attention here. The proposed demonstration is not budget-neutral and will incur significant program costs. The Commission has a long-standing recommendation regarding the Agency's overly broad use of demonstration authority, a recommendation made in 2006 in connection with a program to provide additional payments to oncologists.[4] Subsequently, with respect to two program-wide demonstrations under Part D, the Commission reiterated that "the Secretary should use…demonstration authority to test innovations in the delivery and quality of health care. Demonstrations should not be used as a mechanism to increase payments.…[The] demonstration authority is intended for smaller scale projects that help decision makers learn about innovations in financing and delivering Medicare services."[5] Like the Part D demonstrations, the MA QBP demonstration is a program that "increases program spending at a time when Medicare already faces serious problems with cost control and long-term financing."[6]

The design of the demonstration is also a matter of concern. We believe that the demonstration sends the wrong message about what is important to the program and how improved quality can best be achieved. PPACA established a system of quality bonuses for MA plans beginning in the year 2012, under which plans with the highest quality ratings—4 stars or higher in a 5-star rating system—would have their benchmark amounts (the basis of MA payments) increased. Plan rebates would also vary by the level of stars a plan achieved. However, under the demonstration, plans with three or more stars (combined Part C and Part D ratings) are eligible for bonus payments (though at levels lower than higher-rated plans). CMS's rationale for this approach is that it provides a "strong incentive for…plans to improve performance at various star rating levels" and "additional incentive to achieve quality improvement," which "will lead to more rapid and larger program-wide increases in plan quality scores during the three-year period of the demonstration."[7]

The extension of quality bonuses to the vast majority of plans is likely to result in far greater program costs than the reward system enacted in PPACA. Using the 2011 ratings—that is, those currently shown on the CMS web site for the open enrollment season—80 percent of MA enrollees are in plans with 3 or more stars, while 7 percent are in plans with fewer than 3 stars and 13 percent of enrollees are in plans that are not rated. Plans with 4 or more stars enroll about 23 percent of MA enrollees (as of November 2010). As compared to the design of the bonus system in PPACA, in which the incentive was for plans to try to achieve the highest possible star ratings, and there was consequently a disincentive for poor performance, the demonstration lessens the incentive to achieve the highest level of performance.

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[4] Medicare Payment Advisory Commission. 2006. *Report to the Congress: Effects of Medicare payment changes on oncology services*. Washington, DC: MedPAC.
[5] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
[6] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
[7] *Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Demonstration on Quality Bonus Payments*. CMS: November 10, 2010. Accessed December 16, 2010 at http://www.cms.gov/apps/docs/Fact-Sheet-2011-Landscape-for-MAe-and-Part-D-FINAL111010.pdf.

Another concern is that the combining of Part C and Part D scores (the basis of the overall star rating for determining bonuses), and the weighting methodology used to determine stars, produce some anomalous results in what kinds of plans can obtain bonuses. For example, CMS has instituted a new practice of highlighting, on the Plan Finder Tool at the medicare.gov web site, those plans that have been poor performers over three consecutive years. Poor performance is defined as having health and/or drug plan summary ratings of 2.5 or below for three consecutive years.[8] With the demonstration setting the bonus threshold at 3 stars, and with the combining of Part C and Part D measures (which did not occur in the three preceding years), there are 9 of these poor-performing plans that have a 3-star combined rating that would make them eligible for a quality bonus payment. While these plans have 3-star ratings using the combined Part C and Part D approach, these plans' overall rating for just the Part C measures (excluding the Part D drug measures) is at 2.5 for this year.

The Commission has also noted that administrative measures can compose a large component of a plan's star ratings in some cases. Combining the C and D ratings adds more administrative measures as a proportion of the total (because 10 of 15 of the Part D measures for MA drug plans are administrative). This results in some rating anomalies. For example, one plan has no reported results on the clinical quality of care other than those reported through the member survey, the Consumer Assessment of Healthcare Providers and Systems (CAHPS). CAHPS collects information about the rate of flu and pneumonia vaccinations, and about member experiences of care (accessibility of care and a person's rating of the care and the health plan). For the vaccination measures, this particular plan received a 1-star rating in each measure, the lowest possible star rating, because of the low rate of immunizations. However, the plan received good ratings on other CAHPS measures and on the administrative measures that CMS tracks, resulting in an overall 3-star rating, and making the plan eligible for a bonus payments under the demonstration.

We would urge CMS to reconsider its decision to use demonstration authority to implement a costly program-wide quality bonus program for MA in which the large majority of plans receive bonuses. The statutory language of PPACA that authorizes quality bonuses in MA gives the Secretary great leeway in designing a 5-star system to reward better-performing plans. CMS should work within that authority to design a system to reward the best plans and to encourage improvement among poorer-performing plans.

Conclusion

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

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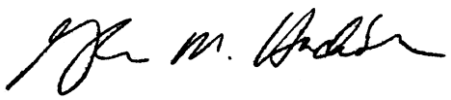
[8] *Update on the Plan Rating System and Plan Finder Tool*. Memorandum to Medicare Advantage and Part D Quality Contacts and Medicare Compliance Officers from Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit and C & D Data Group. August 16, 2010.

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

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

GMH/cz/w