March 5, 2018

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Advance Notices of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) CMS-HCC Risk Adjustment Model, Capitation Rates, Part C, and Part D Payment Policies and 2019 draft Call Letter

Dear Administrator Verma:

The American Academy of Home Care Medicine (Academy) appreciates the opportunity to provide comments on the Advance Notices of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) CMS-HCC Risk Adjustment Model, Capitation Rates, Part C, and Part D Payment Policies and 2019 draft Call Letter (Advance Notices).

The Academy has been serving the needs of thousands of home care medicine professionals since 1984. Our members include home care physicians, nurse practitioners and physician assistants who make house calls, care for homebound patients, act as home health agency and hospice medical directors, and refer patients to home care agencies; home care organizations; medical directors of managed care plans; and administrators of medical groups interested in home care. Their specialties include internal medicine, family practice, pediatrics, geriatrics, psychiatry, and emergency medicine. The Academy delivers on the promise of interdisciplinary, high-value health care in the home for all people in need by promoting the art, science, and practice of home care medicine.

In its Advance Notices, the agency is proposing several changes to the MA program and to the risk adjustment (RA) model. In this letter, the Academy provides comments in response to these proposed changes, outlined as follows:

- New Condition Counts RA Model and Adding Dementia HCCs 51 and 52 as Payment HCCs.
- ESRD RA Model for CY 2019.
- Frailty Adjustment for PACE Organizations and FIDE SNPs.
- Updating the PACE RA Model.
- Health Related Supplemental Benefits.
- Rewards and Incentives for Completion of a Health Risk Assessment (HRA).
- 2019 Star Ratings and Future Measurement Concepts.

New Condition Counts RA Model and Adding Dementia HCCs 51 and 52 as Payment HCCs

In compliance with the 21st Century Cures Act, the agency conducted an analysis of various approaches to take into account the total number of diseases or conditions of individuals enrolled in an MA plan as part of the RA model. CMS evaluated the impact of a "payment condition count model," which only included those HCCs eligible for payment, as well as the impact of an "all condition count model," which included non-payment HCCs. The agency found that the payment condition count decreases both over and under prediction in various deciles but slightly increases the under prediction for beneficiaries with five or more chronic conditions, while the all condition count improves the predictive accuracy for those beneficiaries with over five conditions but reduces the predictive accuracy of the model across almost all deciles. The Academy supports CMS' proposal to move forward with payment condition count over the all condition count which it believes will reduce the accuracy of the RA model in full.

The Academy supports the proposal for including condition counts into the RA model. Academy members provide home-based primary care (HBPC) to some of the sickest, frailest, and highest cost patients, for whom HBPC has been shown to improve care at the same or even reduced costs in Medicare (including MA)[1] as well as the Programs of All-Inclusive Care for the Elderly (PACE). Accurate prediction of costs for this high-risk and high-cost population using the RA model has been an ongoing priority for the Academy. Given the complexity of the HBPC population, the RA model often under-predicts costs for these patients. Incorporating condition counts in the RA model will help improve the predictive accuracy for this population across all programs.

While the Academy prefers the payment condition count, the Academy stresses the additional importance of ensuring that HCC 51 (Dementia with complications) and HCC 52 (Dementia without complications) are included as payment HCCs in any new model. These conditions are currently included in the end-stage renal disease (ESRD) RA model but excluded as payment conditions from the MA HCC RA model, even though they are clinically meaningful and costly conditions with a prevalence between 30% to 50% in the elderly, complex, and seriously ill HBPC patient population. We believe that the incorporation of these HCCs aligns with and supports CMS' efforts to increase the predictive accuracy of the RA model.

Furthermore, since the RA model is used not only in MA but also in other Medicare programs, including Accountable Care Organizations (ACOs) and other alternative payment models (APMs), the underprediction of this serious ill and complex patient population is a prevalent and significant issue in those programs as well. Updating the RA model to include condition counts and HCCs 51 and 52 will ensure that HBPC and other clinicians are not penalized for specializing in providing high-quality care to complex Medicare beneficiaries, improving patients' outcomes while reducing their overall health care costs to the system.

ESRD RA Model for CY 2019

Currently, CMS uses a separate RA model for ESRD beneficiaries which has not been recalibrated since it was implemented in 2012. CMS is proposing to update and recalibrate the model using

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[1] This has been demonstrated through the application of HBPC concepts and approaches in different Medicare models, including the Independence at Home (IAH) Demonstration, Pioneer and Medicare Shared Savings Program (MSSP), Accountable Care Organizations (ACOs), HBPC provided to Veterans under the Department of Veterans Affairs (VA), and HBPC in the Comprehensive Primary Care Plus (CPC+) model.

more recent data (2014 diagnoses predicting 2015 expenditures). Additionally, CMS intends to update the Medicaid factors used in the model to be concurrent with the payment year.

The Academy supports this proposal to update the ESRD model. As mentioned previously, this model includes HCCs 51 and 52 and demonstrates the importance of incorporating these conditions. We reiterate the importance of carrying over this policy and applying it to the RA model as well so that there is alignment between both. The Academy encourages the agency to streamline the RA model so there is only one version, the most recent and accurate version, that is utilized across all programs. This will provide consistency and increased accuracy across all programs, eliminating the current variation and inefficiency due to different versions of the model being utilized in different programs. Additionally, we encourage the agency to consider further tailoring the risk adjustment model for specific higher-risk patient populations (e.g., the Independence at Home (IAH) demonstration population), with an additional adjustment factor that would take into account the model residuals for those specific patient populations.

Frailty Adjustment for PACE Organizations and FIDE SNPs

Complementary to its proposal to implement the payment condition count model, CMS is also proposing updated frailty factors based on this new model. These frailty factors are included in the calculation that determines frailty scores for Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs). The Academy supports this proposal and, to further increase the predictive accuracy of the RA model in its application across programs, recommends that the agency explore calibrating the frailty factors at the county (or groups of counties) level. There is precedence for this as the agency did this with the PACE Physical Disability Pilot to account for the variations at the county level for a more accurate model.

Updating the PACE RA Model

The agency is not proposing any changes to the PACE model at this time. The Academy encourages the agency to update the PACE RA model, so it aligns with the updates being proposed with the new payment condition count model and the ESRD MA model. PACE currently utilizes an outdated version of the RA model that is much older than current versions of both the RA model and the current ESRD RA model. This is demonstrated by the proposed normalization factor of 1.159 for the PACE program. The Academy stresses the need for updating the PACE RA model and recalibrating it with updated data.

Again, we encourage the agency to streamline the RA model that is utilized across all programs to the greatest extent possible—MA, Medicare programs, PACE, and ESRD—and update these models concurrently; rather, than updating each RA model at varying and arbitrary periods of time.

Health Related Supplemental Benefits

Currently, CMS does not allow an item or service to be eligible as a supplemental benefit if the primary purpose is daily maintenance. However, CMS intends to expand the scope of the primarily health related supplemental benefit standard and under its new interpretation, in order for a service or item to be primarily health related, *"it must diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization."* Supplemental benefits under this broader interpretation must be medically appropriate and ordered by a licensed provider as part of a care plan if not directly provided by one; supplemental benefits could not include items or services solely to induce enrollment by MA plans.

The Academy supports the new interpretation and expansion of supplemental benefits that can be provided to patients. This will be a valuable modification to the program for seriously ill and complex patients who will benefit tremendously from receiving additional supplemental benefits that contributes to daily management of their conditions. The Academy encourages the agency to expand the application and implementation of the agency's new interpretation to other programs and models, including ACOs, IAH, etc.

Rewards and Incentives for Completion of a Health Risk Assessment (HRA)

CMS recognizes that HRA tools must be designed to objectively assess and analyze the medical, functional, cognitive, psychosocial and mental health needs of each beneficiary, and therefore do not consist of material that is susceptible to bias like other enrollee satisfaction and outcome surveys. Therefore, beginning CY 2019, CMS is proposing to permit MA plans to include the completion of an HRA as a permitted health-related activity in an RI (Rewards and Incentives) Program.

The Academy, on behalf of its members and their patients, commends CMS for permitting completion of an HRA as an activity in the RI Program. We believe that it is important that patients receive at minimum the same range of services regardless of the model under which they receive their Medicare benefits. By including the HRA assessment in the RI program will encourage patients to complete these assessments and contribute towards ensuring that their specific needs are being met.

2019 Star Ratings and Future Measurement Concepts

The agency is proposing to make several changes to the measures used for 2019 Star Ratings, including adding new measures and revising and removing existing measures, as well as updating the Display Measures. The Academy encourages the agency to work with measure stewards so that the numerators and denominators take into account the home-limited and home-bound patient populations, so that the measures do not result in any unintended consequences or adverse selection results from not taking these patient populations into consideration for the measure specifications.

Conclusion

Overall, the Academy supports CMS' efforts to update the MA program and the RA models to improve predictive accuracy and for increasing access to necessary and valuable supplemental benefits. These are important factors and elements that contribute to the delivery of high-quality care and improved patient outcomes.

If you have any questions, please contact Ray Quintero at rquintero@healthsperien.com.

Sincerely,

Robert Sowislo
American Academy of Home Care Medicine
Public Policy Chair