

Nov. 25, 2015

TO: [RiskAdjustment@cms.hhs.gov](mailto:RiskAdjustment@cms.hhs.gov)

RE: Request for Comment on Proposed Changes to the HCC Risk Adjustment Methodology

This constitutes the response of Elder Service Plan of Harbor Health to CMS’ request for comment on the proposed changes to the HCC risk adjustment methodology.

# Background

Elder Service Plan of Harbor Health is a Program of All-Inclusive Care for the Elderly that has operated in **Mattapan MA** for over 22 years. We serve nearly 500 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 370 of our enrollees have dementia.

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

# Comments

1. Elder Service Plan of Harbor Health 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. Elder Service Plan of Harbor Health supports the use of the subpopulations’ distinct risk factors for establishing payments to PACE organizations. Elder Service Plan of Harbor Health notes that approximately 97 percent 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”). Elder Service Plan of Harbor Health, 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 85 % of all Elder Service Plan of Harbor Health 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 43 % of Elder Service Plan of Harbor Health enrollees have a diagnosis of CHF, and of these 15%

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 Elder Service Plan of Harbor Health beneficiaries with congestive heart failure and early stage kidney disease significantly.

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.

1. 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 Elder Service Plan of Harbor Health participants, the CMS-HCC risk adjustment model for PACE needs to include HCCs for dementia diagnoses. As noted earlier, approximately 87% of Elder Service Plan of Harbor Health 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.

1. 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.

# 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.

Please direct any questions regarding Elder Service Plan of Harbor Health comments to **Kathryn Burns** at [kburns@hhsi.us](mailto:kburns@hhsi.us) 617-533-2424**.** Again, thank you for your consideration.

Sincerely,

Kathryn C. Burns

VP and Executive Director

Elder Service Plan of Harbor Health