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Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2018-0154
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for the Medicare Advantage (MA) CMS-HCC Risk Adjustment Model

Dear Administrator Verma:

The American Geriatrics Society (AGS) appreciates the opportunity to comment on the “Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for the Medicare Advantage (MA) CMS-HCC Risk Adjustment Model” [hereinafter the “Advance Notice”]. The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners who are devoted to improving the health, independence, and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy.

We appreciate CMS’s continuous efforts to improve risk adjustment and to ensure that payments to MA plans more accurately reflect the health status of the enrolled beneficiaries that geriatricians typically treat -- which include many with multiple, chronic conditions -- by adjusting payments using a risk adjustment model that accounts for demographic variables, the specific health conditions of the beneficiary, and the beneficiary’s total number of conditions.

The AGS applauds CMS’s proposal to adopt a Payment Condition Count (PCC) CMS-HCC risk adjustment model, which accounts for the number or count of conditions a beneficiary has, as an important component of improving payment accuracy, helping to assure that MA plans have the resources needed to meet the healthcare needs of the most vulnerable and costly patient populations. In the Advanced Notice, CMS presents two variants of this model.

The AGS strongly encourages CMS to adopt the “alternative” PCC model in order to account more explicitly for the costs associated with dementia and pressure ulcers and improve predictive power of the CMS-HCC model for high need beneficiaries with these conditions. We agree with CMS’s determination that dementia and pressure ulcers fulfill the criteria for inclusion in the PCC model and

believe that the alternative PCC model would result in more accurate payment for a large group of beneficiaries with highly-specialized needs. Our specific comments are set forth in more detail below.

A. Taking Into Account the Number of Conditions of a Beneficiary

CMS is proposing to implement in PY 2020 a new PCC CMS-HCC model that takes into account the number of payment conditions a beneficiary has, in order to meet requirements in the 21st Century Cures Act (Pub. L. 114-255). This refinement to the current risk adjustment model would result in a determination of the total predicted expenditures for each beneficiary based on: (1) demographic variables; (2) the specific conditions the beneficiary has that are in the model; and (3) the total number of conditions that the beneficiary has. CMS also proposes to cap the count variables in the PCC model at ten conditions because the Agency is concerned that the clinical nature of the model would be significantly reduced if it were to include all count variables that met the statistical criteria.

The AGS strongly supports CMS's inclusion of additional variables accounting for the number of conditions experienced by a beneficiary. Geriatricians provide primary care to the sickest and most complex Medicare beneficiaries, a population characterized by the presence of multiple, co-existing chronic conditions and a high prevalence of frailty. Research demonstrates that the presence of multiple chronic conditions in a patient "has a profound impact on health, healthcare utilization, and associated costs"¹ and many studies have observed a "positive association of [multiple chronic conditions] and use/costs, many of which found that use/costs significantly increased with each additional condition."² Patients with multiple chronic diseases cannot be treated as though these conditions exist independently of one another, and a "whole patient" orientation is a core principle of geriatric primary care. A PCC model which accounts for the number of payment conditions a beneficiary has supports a "whole patient" approach by taking into account the complexity of multiple diseases, medications, and symptoms faced by many geriatric patients.

Research further demonstrates that the number of HCCs independently predicts risk, and that adding a condition count will improve payment accuracy. As the Medicare Payment Advisory Commission (MedPAC) concluded, "using the number of conditions a person has as a risk adjustment factor" would likely "lead to more accurate payments to MA plans caring for beneficiaries with chronic conditions."³ Proper risk adjustment is critical to ensuring that MA plans receive more accurate payments for the frail, multi-morbid beneficiaries our members treat, and that MA plans are not incentivized to discourage enrollment of the sickest Medicare beneficiaries. Indeed, CMS implemented a risk adjustment methodology that took into account health status with "the intention . . . to reduce the incentive for plans to prefer enrolling healthier-than-average beneficiaries."⁴

¹ Donna M. Zulman, et al., *Quality of Care for Patients with Multiple Chronic Conditions: The Role of Comorbidity Interrelatedness*, 29 J. Gen. Internal Med. 529 (2013). Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3930789/>.

² Thomas Lehnert, et al., *Review: Healthcare Utilization and Costs of Elderly Persons With Multiple Chronic Conditions*, 68 Am. J. M. Quality (2011). Available at <https://www.ncbi.nlm.nih.gov/pubmed/21813576>.

³ Mark E. Miller, *Improving Care for Medicare Beneficiaries with Chronic Conditions*, Statement to Senate Committee on Finance (May 14, 2015). Available at <http://www.medpac.gov/docs/default-source/congressional-testimony/testimony-improving-care-for-beneficiaries-with-chronic-conditions-senate-finance-.pdf?sfvrsn=0>.

⁴ CMS *Report to Congress: Medicare Advantage Risk Adjustment* (December 2018). Available at <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvvtgSpecRateStats/Downloads/RTC-Dec2018.pdf>.

As enrollment in MA plans continues to increase, it is critically important that Medicare's payment rates to MA plans are adequate for the healthcare needs of all of the sickest and most costly beneficiaries.⁵

B. Alternative PCC Model

AGS strongly urges CMS to adopt its alternative PCC model, which would include additional HCCs for dementia and pressure ulcers. According to the Advanced Notice, CMS research found that some beneficiaries with multiple chronic conditions, including those with dementia and pressure ulcers, were under-predicted by the CMS-HCC model. After evaluating such conditions against three criteria -- (1) condition category is clinically meaningful; (2) condition category predicts medical expenditures; and (3) condition category does not comprise discretionary diagnoses -- CMS determined that dementia and pressure ulcers met the criteria for inclusion in the model. CMS included detailed estimates of the results of an "alternative" model specification including these three variables.⁶ However, CMS does not discuss why it prefers its proposed model over the alternative model.

We would like to emphasize the importance of these two conditions in the healthcare of the Medicare population. Care for dementia poses significant and unique healthcare challenges. Dementia is typically a disease of later life, generally beginning after 65 years of age. Alzheimer's disease, the most common type of dementia, affects an estimated 5.5 million people in the United States. Dementia's social and economic implications -- in terms of direct medical costs, direct social costs, and the costs of informal care -- are significant. According to the World Health Organization (WHO), the total global societal cost of dementia in 2015 was estimated to be \$818 billion, equivalent to 1.1% of global gross domestic product.⁷ Patients with dementia often have multiple additional chronic diseases which "may accelerate progression towards a state of cognitive and functional impairment that results in the under-diagnosis and under-treatment of dementia . . . [and] lead to extended hospital stays and increased healthcare costs and mortality rates for hospitalized patients."⁸ Furthermore, complex comorbidity among dementia patients can frustrate care for both dementia and other chronic conditions.⁹

⁵ See Timothy Sullivan, M.D., *Medicare Should Pay Doctors More, Not Less, For Treating the Sickest Patients*, Stat News (Aug. 15, 2018). Available at <https://www.statnews.com/2018/08/15/medicare-payments-doctors-sickest-patients/>.

⁶ Advanced Notice, pp. 9 – 11. In the alternative model, the coefficients for HCC 51 (Dementia with Complications) and HCC 52 (Dementia without Complications) would be constrained to be equal to one another so as to limit any effect that clinical discretion may have in payment.

⁷ American Geriatrics Society (AGS) Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine (G. Michael Harper, William L. Lyons, & Jane F. Potter eds., 10th ed. 2019).

⁸ Beatriz Poblador-Plou, et al., *Comorbidity of Dementia: A Cross-Sectional Study of Primary Care Older Patients*, 14 BMS Psychiatry (2014). Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3994526/>.

⁹ Frances Bunn, et al., *Comorbidity and Dementia: A Scoping Review of the Literature*, 12 BMS Medicine (2014). Available at <https://bmcmedicine.biomedcentral.com/track/pdf/10.1186/s12916-014-0192-4>. For the reasons, presented in this paragraph, CMS added a new code that described an evidence-based cognitive service in the 2017 Physician Fee Schedule. The AGS played a lead role in the development of this code with support from the American Psychiatric Association (APA) and the American Academy of Neurology (AAN). This service is provided when a comprehensive evaluation of a new or existing patient exhibiting signs of cognitive impairment is required to establish a diagnosis etiology and severity for the condition. The service includes a thorough evaluation of medical and psychosocial factors potentially contributing to increased morbidity. The code addresses issues related to caring for patients with cognitive impairment such as dementia, management of symptoms, assessment

Pressure injuries are a common chronic wound in the geriatric population, affecting between 1.3 and 3 million adults in the United States. These injuries cause serious pain and are associated with a decreased quality of life, longer hospital stays, increased chance of readmission within 30 days after hospital discharge, increased chance of admission to a long-term care facility, and increased risk of death. Infectious complications include cellulitis, abscess, sepsis, pyarthrosis, and osteomyelitis. Pressure injuries often require surgical procedures ranging from sharp debridements to myocutaneous flaps, amputations, and ostomies for fecal diversion. According to the Agency for Healthcare Research and Quality (AHRQ), pressure injuries cost \$9.1 to \$11.6 billion per year, with the cost of individual patient care ranging from \$20,900 to \$151,700 per pressure ulcer.

As these summaries indicate, these conditions are of immense clinical importance in the Medicare population. Accordingly, we urge inclusion of these variables in the PCC-HCC model specification – that is, we urge CMS to adopt the “alternative” model. CMS’s discussion of the results of the alternative model notes that in the community full-risk segments, coefficients on the added count variables were positive and statistically significant. The institutionalized segment did not exhibit similar results, which CMS attributes to relatively low variance of costs of the institutionalized population.¹⁰ We believe that CMS should adopt the alternative model because of the improved results for the community segment. As the Baby Boom generation ages, the aggregate burden of institutionalization will increase substantially. Insofar as MA plans are provided resources that reflect more accurately the costs of care of patients in the community, particularly for demented patients, we believe they will have stronger incentives to help keep these individuals in the community, preventing institutionalization in instances where this step may not be fully necessary.

The risk adjustment model should take into consideration both the impact of specific condition categories that meet the specified criteria AND the impact of multiple chronic conditions. CMS should not forgo capturing the impact of the meaningful condition categories for dementia (HCC 51 and 52) and pressure ulcers (159) in order to maintain positive and statistically significant impact of the count variable for a small subset of institutionalized beneficiaries. CMS notes that the variation in cost is smaller with institutional beneficiaries than community beneficiaries and the effect of the count variable in explaining that variation is more modest: it is not until beneficiaries have six or more chronic conditions that the count variable is both positive and significant in the institutional segment. While we believe the count variable is an important addition to the risk adjustment methodology, reliance on this variable needs to be balanced against the additional explanatory value obtained by including the dementia and pressure ulcer HCCs. In risk adjusting payment for a specific beneficiary, these new condition categories are of greater relevance to beneficiaries in both the institutional and community segments than the count variable, if, for example, dementia is one of four or fewer conditions with which the patient has been diagnosed. CMS should follow its standard methodology and include the condition categories that meet the required criteria for inclusion in the model for payment -- in this case the dementia and pressure ulcer HCC -- regardless of the impact that inclusion of those additional categories may have on other risk factors, such as the count variables.

With these considerations in mind, the AGS strongly believes that the alternative PCC model reflects the overriding clinical importance of both dementia and pressure ulcers for the most vulnerable Medicare beneficiaries. Accordingly, we urge adoption of CMS’ alternative model.

of decision-making capacity, addressing caregiver stress, and other factors important to providing competent and comprehensive care.

¹⁰ Advanced Notice, p. 11.

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Thank you for the opportunity to submit these comments. We would be pleased to answer any questions you may have. Please contact Alanna Goldstein at agoldstein@americangeriatrics.org.

Sincerely,



Laurie Jacobs, MD, AGSF
President



Nancy E. Lundebjerg, MPA
Chief Executive Officer