

June 22, 2015

The Honorable Orrin Hatch  
Chairman, Senate Committee on Finance

The Honorable Ron Wyden  
Ranking Member, Senate Committee on Finance

The Honorable Johnny Isakson  
Co-Chair, Chronic Care Working Group  
Senate Committee on Finance

The Honorable Mark Warner  
Co-Chair, Chronic Care Working Group  
Senate Committee on Finance

*via electronic mail*

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

DaVita appreciates the opportunity to submit recommendations to the Senate Finance Committee's Chronic Care Working Group. As the nation's largest operator of medical groups and physician networks, we care for 959,000 health plan members, including 348,000 Medicare Advantage (MA) enrollees. We also operate and provide administrative services at over 2,000 outpatient dialysis centers, serving nearly 174,000 patients with end stage renal disease (ESRD).

For more than 20 years, DaVita has been a leader in offering integrated care and developing innovative delivery strategies with the goals of improving quality and outcomes. The fact that more than half of our ESRD facilities have achieved a 4 or 5 star rating under the Centers for Medicare & Medicaid Services (CMS) 5-star quality rating system clearly demonstrates our strong commitment to those goals. In MA, we uniformly perform at the 4 and 5 star level on clinical measures.

We have significant experience in caring for chronically ill patients in fee-for-service (FFS) and managed care, and know first-hand the importance of care management. As you know, ESRD are among the sickest and frailest of all beneficiaries. We, better than most providers, understand the need to develop comprehensive care management plans for beneficiaries with ESRD. Programs should be established to allow these beneficiaries to benefit from improved care coordination and delivery of additional benefits/supports in order to better manage their conditions.

Our recommendations, summarized below, focus on the need to: (1) improve the MA risk adjustment model's accuracy and transparency and (2) create new opportunities for health plans, as well as health systems and provider groups, to serve beneficiaries with multiple chronic conditions.

DaVita commends the Senate Finance Committee for establishing the Chronic Care Working Group. We encourage the exploration of additional care delivery models that will improve care coordination and outcomes, and expand coverage options for this chronically ill population. We look forward to discussing our recommendations with the Committee and Working Group.

Sincerely,



LeAnne Zumwalt  
Group Vice President

**Recommendations Related to the MA Risk Adjustment Model**

- Apply the 2015 blend percentages in PY 2017
- Ensure additional transparency when developing and implementing proposed changes
- Require the Centers for Medicare & Medicaid Services (CMS/Agency) to conduct statistical analyses; publicly release the filtering logic before using encounter data to calculate risk scores; and ensure that encounter data capture MA plans' investments in care coordination activities

**Recommendations Related to Alternative Care Delivery Models**

- Adopt provisions included in S. 598, the Chronic Kidney Disease Improvement in Research and Treatment Act of 2015, bipartisan legislation introduced by Senator Cardin with original cosponsors Senators Crapo and Nelson, to:
  - Permit beneficiaries with ESRD to elect a MA plan
  - Establish a voluntary ESRD Coordinated Care Program
- Build on S. 598 by creating additional alternative care delivery models for health systems and provider groups to serve beneficiaries with ESRD on a capitated basis

**IMPROVEMENTS TO THE MEDICARE ADVANTAGE RISK ADJUSTMENT SYSTEM TO ENSURE PAYMENT ACCURACY AND PROMOTE TRANSPARENCY**

**I. BACKGROUND**

Medicare statute requires the Centers for Medicare & Medicaid Services (CMS/Agency) to risk adjust Medicare Advantage (MA) payments to reflect enrollees’ health status and other characteristics. Risk adjustment helps mitigate incentives for MA plans to avoid enrolling sicker beneficiaries. Risk adjustment also ensures that MA plans receive adequate reimbursement to commit resources in care delivery strategies aimed at helping beneficiaries, especially those with one or more chronic conditions, avoid complications and further progression of those conditions. CMS has substantial discretion in designing and implementing a risk adjustment system and currently uses the CMS-Hierarchical Condition Category (CMS-HCC) model. Although the CMS-HCC model is an improvement over previous models, recent changes, described briefly below, have created an unstable payment environment for MA plans.

**a. Implementation of 2014 CMS-HCC Model**

For plan year 2014, CMS proposed using the 2014 CMS-HCC model (2014 model), which among other changes, added, revised, or eliminated certain condition categories including some related to chronic kidney disease (CKD) despite the evidence of the increased costs associated with CKD patients. Stakeholders raised significant concern that the 2014 model would artificially lower risk scores and payments when MA plans already faced other statutory reductions, which would challenge MA plans’ ability to offer high-quality services. The Medicare Payment Advisory Commission (MedPAC) also expressed concern that CMS was inappropriately using the 2014 model to adjust for coding differences between MA plans and FFS providers when it already has a separate statutory mechanism to do so.<sup>1</sup> In response to those concerns, CMS opted to calculate beneficiary risk scores by blending the 2013 and 2014 models for MA plan payments in 2014 and 2015. CMS has finalized its proposal to fully implement the 2014 model for the 2016 plan year. As shown in the table below, the extent to which CMS has used the 2014 model has varied dramatically from year to year.

Plan Year	Blend Percentages			
	Proposed in Advance Notice		Announced in Final Notice	
	2013 Model	2014 Model	2013 Model	2014 Model
2014	0	100	25	75
2015	25	75	67	33
2016	0	100	0	100

**b. Use of Encounter Data to Determine Risk Scores**

In 2012, CMS began collecting data from MA organizations regarding every item and service provided to a MA enrollee. In addition to diagnoses, these encounter data include treatment (i.e., CPT-4 codes) and payment information. In the 2016 Final Notice, CMS affirmed its proposal to begin using encounter data to determine beneficiary risk scores. Specifically, CMS will base 10 percent of a beneficiary’s risk score on encounter data and 90 percent on risk adjustment processing system (RAPS) data.

<sup>1</sup> [http://www.medpac.gov/documents/comment-letters/medpac-comment-on-cms's-advance-notice-of-methodological-changes-for-calendar-year-\(cy\)-2014-for-medicare-advantage-\(ma\)-capitation-rates-part-c-and-part-d-payment-policies-and-2014-call-letter.pdf?sfvrsn=0](http://www.medpac.gov/documents/comment-letters/medpac-comment-on-cms's-advance-notice-of-methodological-changes-for-calendar-year-(cy)-2014-for-medicare-advantage-(ma)-capitation-rates-part-c-and-part-d-payment-policies-and-2014-call-letter.pdf?sfvrsn=0)

## II. RECOMMENDATIONS

DaVita strongly supports efforts to improve the accuracy of and to promote greater transparency regarding changes to the MA risk adjustment model. Improved accuracy will ensure that MA plans and providers have adequate resources to meet their enrollees' health care needs. Greater transparency will help ensure a more stable payment environment by affording plans additional opportunities to understand and offer feedback on the development and implementation of changes to the model. Below we offer a series of recommendations aimed at achieving those objectives, which is even more critical as the number of beneficiaries living with one or multiple chronic conditions continues to grow.

### **Recommendation 1: Apply the 2015 Blend Percentages in PY 2017.**

**Description:** Use the current approach of calculating risk scores by blending the 2013 model and 2014 model at 67 percent and 33 percent, respectively.

**Rationale:** Although the CMS-HCC model has better predictive strength compared to prior models, researchers, including those at MedPAC, have found that it tends to over-predict costs for very low-cost beneficiaries and under-predict costs for very high-cost beneficiaries.<sup>2</sup> This shortcoming has serious implications for MA plans and providers caring for higher numbers of sicker, more costly enrollees. The 2014 model does not address this fundamental weakness. In addition, CMS estimated that the 2014 model's full implementation would decrease MA plan payments by 1.7 percent in 2016. This decrease comes on top of \$18 billion in statutory payment reductions that the Congressional Budget Office (CBO) estimated for 2016.<sup>3</sup>

Further, by removing condition categories for CKD, the 2014 model sets back MA plans' efforts to identify enrollees with CKD and to deliver benefits and services to slow the disease's progression. This is absolutely contrary to the findings of a study by researchers at Research Triangle International (RTI), the University of Michigan, and the Centers for Disease Control and Prevention (CDC), who found that medical costs attributable to Medicare beneficiaries with early stage CKD are substantial. The authors reported the findings "highlight the need to identify CKD in its earliest stages to prevent disease progression and avoid the high medical costs attributable to the latter stages of the disease."<sup>4</sup>

CMS has stated that it removed the CKD condition categories due to concern that MA plans were over-coding compared to FFS. Clearly, CMS must address over-coding. However, MedPAC's view is that it should be accomplished through the coding intensity adjuster, not the risk adjustment model. We also question the Agency's conclusion that MA plans over-code CKD conditions given evidence of significant under-reporting of renal-related diagnoses, including among patients covered by the Department of Veterans Affairs and Medicare FFS.<sup>5,6</sup>

In sum, maintaining the current blend amounts will mitigate the 2014 model's negative impact on risk scores, payments, and MA plans' efforts to help chronically ill beneficiaries avoid costly complications and progression of their conditions. In addition, it will afford policy makers and stakeholders the opportunity to develop and consider structural and other changes to improve the model's accuracy.

<sup>2</sup> [http://www.medpac.gov/documents/reports/jun14\\_ch02.pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/jun14_ch02.pdf?sfvrsn=0)

<sup>3</sup> <https://www.cbo.gov/sites/default/files/43471-hr6079.pdf>

<sup>4</sup> <http://jasn.asnjournals.org/content/early/2013/07/29/ASN.2012040392.full.pdf+html>

<sup>5</sup> <http://jasn.asnjournals.org/content/early/2013/07/29/ASN.2012040392.full.pdf+html>

<sup>6</sup> <http://www.medscape.com/viewarticle/538871>

**Recommendation 2: Ensure Additional Transparency When Developing and Implementing Proposed Changes to the Risk Adjustment Model.**

**Description:** Require CMS to: (1) afford MA plans and other interested parties, including providers, additional opportunities to review and comment on proposed changes through a formal rulemaking process; (2) disclose all clinical and other analyses to support proposed changes to the risk adjustment model; and (3) obtain a certification from the Office of the Actuary to verify that proposed changes improve the risk adjustment model's accuracy.

**Rationale:** CMS has significant discretion in developing and implementing changes to the risk adjustment model that can have a significant impact on payments. As such, this process should be as open and transparent as possible. The Annual Notice process, which provides for a 45-day comment period, is a primary vehicle used to announce proposed changes as required by Section 1853(b) of the Social Security Act. Given the effect on payments, MA plans and other interested parties should have additional time to assess the impact of proposed changes and to prepare for their possible implementation. A formal rulemaking process along with a requirement that CMS announce proposed changes well in advance of implementation would afford plans this opportunity. As part of that process, CMS should disclose and make readily available all clinical and other analyses used in developing proposed changes so that MA plans can better understand the evidence that supports the proposed changes. Finally, certification by the Office of the Actuary that the proposed changes improve the model's accuracy would provide an additional level of transparency.

**Recommendation 3: Require CMS to Conduct Statistical Analyses, Publicly Release Filtering Logic, and Ensure that Encounter Data Capture Care Coordination Investments before Using Encounter Data to Calculate Risk Scores.**

**Description:** Require CMS to: (1) conduct statistical analyses as recommended by the Government Accountability Office (GAO) to assess the accuracy and completeness of encounter data; (2) provide MA plans sufficient opportunity to review and comment on the filtering logic before the Agency can use encounter data to determine risk scores; and (3) ensure that encounter data reflect MA plans' investments in care coordination. At the very least, Congress should require CMS to meet these conditions before increasing the percentage of encounter data used to determine risk scores.

**Rationale:** Plans have worked in good faith with CMS to address systems issues that have challenged their ability to submit and for CMS to accept encounter data. Although progress has been made in resolving these issues, CMS has not validated the completeness and accuracy of the data. As such, it is premature for CMS to move forward in using encounter data to calculate risk scores. In a July 2014 study, the GAO raised similar concerns, reporting that CMS had yet to conduct statistical analyses to determine the encounter data's completeness and accuracy.<sup>7</sup> In addition, although MA plans submit encounter data for all sites of care, the risk adjustment model includes data only from certain sites of care. To date, CMS has not released the filtering logic that it will apply to ensure that only encounter data from sites of care included in the model are used to calculate risk scores. In the absence of the filtering logics, MA plans have not had the chance to assess the impact of the use of encounter data in determining risk scores.

Finally, current law requires CMS to evaluate and revise the risk adjustment system in order to account for higher medical and care coordination costs associated with frailty, individuals with multiple chronic conditions, individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions. CMS issued an evaluation in 2011, which predates its decision to use encounter data for risk adjustment purposes. DaVita is not aware of any subsequent analyses and strongly recommends that Congress require CMS to demonstrate that it has taken sufficient steps to ensure that encounter data capture care coordination costs before moving forward in using the data for risk adjustment purposes.

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<sup>7</sup> <http://www.gao.gov/assets/670/665142.pdf>

## CREATING ADDITIONAL ALTERNATIVE CARE DELIVERY MODELS

### I. BACKGROUND

Beneficiaries with one or more chronic illness often see multiple providers, take multiple prescriptions, and face challenges, such as lack of transportation, that can hinder their ability to adhere to recommended treatment regimens. MA plans have long served as an alternative care model for beneficiaries with a chronic illness, and they have made great strides in improving health outcomes and quality of care for these beneficiaries. However, one group of chronically ill beneficiaries – those with end-stage renal disease (ESRD) – have had limited alternatives to FFS. Although beneficiaries who develop ESRD while enrolled in a MA plan can remain enrolled, beneficiaries with ESRD in FFS cannot elect a MA plan, except in limited circumstances.

Patients with ESRD often have co-morbid conditions, including anemia, diabetes, cardiovascular disease, and hypertension.<sup>8</sup> Depression also is common among ESRD patients with estimated prevalence as high as 20 percent to 25 percent.<sup>9</sup> Given their complex health care needs, it is not surprising that Medicare spending on beneficiaries with ESRD is high. In 2010, Medicare spent \$75,475 for each ESRD beneficiary compared to \$10,093 for each aged beneficiary and \$12,530 for each beneficiary under age 65 enrolled due to disability. Although beneficiaries with ESRD constituted 1.0 percent of the Medicare population in 2010, they accounted for a disproportionate share – 6.5 percent – of total Medicare spending.<sup>10</sup> These facts strongly point to the need for additional alternative care delivery models for beneficiaries with ESRD that promote better care coordination and value to the Medicare program.

### II. RECOMMENDATIONS

DaVita welcomes the efforts to devise new ESRD payment and care delivery strategies, including bundled payments and the ESRD Seamless Care Organization (ESCO) program. These initiatives are a solid step forward. We strongly encourage the Committee and Chronic Care Working Group to build on these efforts and continue to broaden the availability of alternative care models to serve chronically ill beneficiaries, including models through which health care systems and provider groups can serve beneficiaries with ESRD.

**Recommendation 1: Adopt provisions included in S. 598, the Chronic Kidney Disease Improvement in Research and Treatment Act of 2015, bipartisan legislation introduced by Senator Cardin with original cosponsors Senators Crapo and Nelson.**

**Description:** Revise current statute to: (1) allow FFS beneficiaries with ESRD to elect a MA plan and (2) establish a voluntary ESRD coordinated care program.

**Rationale:** Fifteen years ago, MedPAC recommended that once CMS implemented a risk adjustment payment and a system to monitor quality of ESRD care, Congress should lift the bar on prohibiting patients with ESRD from enrolling in MA plans. In 2005, CMS implemented a separate and specific risk adjuster for beneficiaries with ESRD. CMS also now has in place the 5-star rating system to monitor quality of care for MA plans and dialysis facilities.

Establishing a voluntary coordinated care program would provide an additional avenue to better align financial incentives under Medicare FFS and afford physicians and dialysis providers the opportunity to work together to improve care for beneficiaries with ESRD.

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<sup>8</sup> <http://www.medscape.org/viewarticle/736181>

<sup>9</sup> <http://www.ncbi.nlm.nih.gov/pubmed/17904499>

<sup>10</sup> <http://www.medpac.gov/documents/data-book/june-2014-data-book-section-2-medicare-beneficiary-demographics-.pdf?sfvrsn=0>

**Recommendation 2: Build on policies included in S. 598 by establishing alternative care delivery models in addition to the MA program that allow health systems and provider groups to serve beneficiaries with ESRD.**

**Description:** Establish a program through which Medicare providers and suppliers, including dialysis facilities, physician group practices, and groups of affiliated physicians can enter partnerships to deliver Medicare and other benefits to beneficiaries with ESRD on a capitated basis.

DaVita has been working to develop a proposal to establish such a program. Under the proposal, providers, suppliers and other entities involved in the partnerships would be allowed to accept capitated payments only after demonstrating expertise in caring for ESRD patients. They also must submit an application to CMS, which along with other requirements, outlines a comprehensive ESRD care management strategy that includes components such as the use of interdisciplinary care teams, health risk assessments, individualized care plans, transplant evaluations, non-clinical services, such as transportation, and education programs for patients, families, and caregivers, among others.

**Rationale:** Patients with ESRD are among the sickest and frailest of all beneficiaries. They have high rates of co-morbidities and complications and stand to benefit significantly from improved care coordination and delivery of clinical and non-clinical benefits and supports. Health plans have proven their ability to integrate care and offer services that help chronically ill patients maintain their health. DaVita is proud of the contributions that its providers have made through their participation in MA plan networks. That said, we believe that health systems and provider groups, especially those with significant expertise in caring for patients with ESRD, can also deliver superior, high-value care outside of the health plan construct and that Congress should explore additional care delivery models that will improve care coordination and outcomes.