

March 26, 2004

NOTE TO: Medicare Advantage Organizations and Other Interested Parties

SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2005 Medicare Advantage (MA) Payment Rates

In accordance with section 1853(b)(2) of the Social Security Act (the Act), we are notifying you of proposed changes in the MA (formerly called Medicare+Choice) capitation rate methodology and risk adjustment methodology for CY 2005. Preliminary estimates of the national per capita MA growth percentage and the methodology changes for CY 2005 are also attached. For 2005, CMS will announce the MA rates on the second Monday in May before the calendar year concerned, in accordance with Section 532 of P.L. 107-188, the Public Health Security and Bioterrorism Response Act of 2002. This Advance Notice is published 45 days before that date.

Attachment I sets forth in detail the changes in payment methodology for 2005. As explained in Attachment I, the Medicare Modernization Act of 2003 (MMA) modified the MA payment methodology. For 2005, all rates will be the greater of the 2004 MA capitation rate increased by the minimum percentage increase (the greater of 2 percent or the national per capita MA growth percentage) or the 2005 fee-for-service rate. Attachment II shows the preliminary estimates of the national per capita growth percentage for the minimum percentage increase.

Comments or questions may be addressed to:
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In order to receive consideration prior to the May 10, 2004 announcement of MA capitation rates, comments must be received by April 12, 2004.

/ s /
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Attachments

Attachment I

Changes in Methodology Since CY 2004 Rates

There are a number of changes in the MA (formerly called Medicare+Choice) payment methodology for CY 2005. Section A reviews the changes to the MA capitation rates made by the Medicare Modernization Act of 2003 (MMA), Section B describes our rebasing rates reflecting original Medicare fee-for-service (FFS) costs, and Section C describes the new payment methodology for MA ESRD enrollees. Section D reviews the CMS-Hierarchical Condition Category (HCC) model implementation issues.

A. Changes to the 2005 MA Capitation Rates.

The 2005 MA annual capitation rates will reflect all of the payment changes made in Section 211 of the MMA, which provided for “immediate improvements” in the MA program. The MMA replaces the methodology in effect for 2003, under which MA organizations were paid the “highest of three rates” (a “floor” amount reflecting a minimum specified in statute, a minimum percentage increase of 2 percent, or a “blended rate” combining local and national data (subject to a budget neutrality adjustment)). For 2004, the MMA specified a transitional methodology, where the county and State rates were the highest of four rates: the three rates described above which applied for 2003, and a fourth rate based on 100 percent of fee-for-service (FFS) costs under original Medicare. In addition to adding the fourth rate, the MMA modified the minimum percentage increase rate to be the higher of 2 percent or the Medicare growth percentage (see Attachment II). For the next phase, the MMA specified that beginning with 2005, annual capitation rates will be based on the minimum percentage increase rate (as modified), except for years when CMS rebases the original Medicare FFS rate; in rebasing years the rate is the higher of the minimum percentage increase rate or the FFS rate. (See discussion in Section B on rebasing) The MMA requires CMS to rebase the FFS rates no less frequently than every three years; i.e., at least every three years a “higher of two rates” methodology is in effect.

For the 2005 ratebook, the minimum percentage increase rate will be updated by the national growth rate, because this expected trend generates a higher rate than a 102 percent increase over the 2004 MA capitation rate. (See Attachment II). Since we are rebasing the FFS rates for 2005, the final rates will be the greater of the 2004 MA capitation rates increased by the minimum percentage increase rate, or the 2005 FFS rate.

B. Rebasing the FFS Rates for 2005.

CMS has decided to rebase the 100 percent of FFS rate for 2005. Rebasing the FFS rates means that OACT retabulates the per capita FFS expenditures for each county (and for ESRD beneficiaries, for each State) so that the FFS rates reflect more recent county growth trends in FFS expenditures.

Counties with upward growth trends in FFS expenditures in the year(s) since CMS last rebased the FFS rates could have local FFS growth trends that are larger than the national MA growth percentage for that year. Other counties may see a negative trend from the previous to the current FFS trend in local expenditure growth. However, the MMA specifies that in rebasing years, the annual rate is the higher of the FFS rate and the minimum percentage increase rate. As a result, no county would see a decrease in its MA payment rate from one year to the next even if its FFS rate decreased.

For years when we are not required by law to rebase the FFS rates, we will announce whether we will rebase in this Advance Notice.

C. New Payment Methodology for MA ESRD Enrollees.

We are implementing a new approach to improve payments on behalf of enrollees with End Stage Renal Disease (ESRD). Section 605 of The Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000 (BIPA) required CMS to adjust our approach to computing ESRD payment rates to reflect the method used in the ESRD social HMO (S/HMO) demonstration then in place. We interpreted this to mean that ESRD payments to MA organizations should employ the same basic approach as under the ESRD demonstration referenced in section 605. To implement the BIPA provision for 2002, CMS increased the base rates by three percent and began adjusting payments with age and sex factors, while continuing to review other options. Effective January 2005, MA enrollees with ESRD will be incorporated into diagnosis-based risk adjustment using a different version of the CMS-HCC model. (See Exhibit 1 for a draft list of coefficients for each disease group) The new ESRD payment model will align us further with the method used in the ESRD S/HMO demonstration by allowing us to capture co-morbidity information in addition to demographic information and basic disease markers for ESRD beneficiaries. ESRD status is recognized in the payment year. The data for 100 percent of ESRD beneficiaries were used to develop the model.

The three parts of the ESRD CMS-HCC model are:

1. A full risk adjustment model for people on dialysis that is calibrated only on this population, so the payment weights are unique to these beneficiaries. A rescaled state-level ratebook will be created to reflect this population's program costs.
2. We will also make different payments for those who have a kidney transplant and those who have a pancreas transplant simultaneous with the kidney transplant.
3. A modified version of the regular CMS-HCC model for people who have functioning kidney grafts. The model has an additional term to recognize the extra costs of immunosuppressive drugs and higher intensity of care for this group. We will differentiate payments for months close to the transplant period from those further out. The former have a higher intensity of care.

We developed this three-part model in response to our findings on expenditure patterns for ESRD beneficiaries. Dialysis patients have high ongoing costs, while transplant patients incur a very high one-time cost. Functioning graft patients are much more similar to the general population than they are to dialysis patients. Using the same payment weights for all three groups would lead to over- or underpayments to MA organizations that do not have enough ESRD enrollees to have an average mix. To address this problem, CMS developed separate payment approaches for these three populations.

Risk Adjustment Model for Dialysis Patients.

The dialysis model has the same HCC categories as the CMS-HCC model for the non-ESRD population, except that HCCs with kidney disease diagnoses are excluded (HCC128 to HCC132). The model is calibrated only on dialysis patients, so the disease weights used for payment recognize disease and expenditure patterns unique to this population.

The data used for calibrating the ESRD models were 1999 (diagnostic) and 2000 (program payment) data on fee-for-service ESRD beneficiaries. For example, expenditures for a fee-for-service beneficiary on dialysis from January through August 2000 who received a transplant in September 2000 are included in the dialysis group for eight months, but then are excluded. From September through November 2000, this beneficiary's costs are included in the transplant data to determine estimated average transplant costs. As of December 2000, this beneficiary is included in the functioning graft model.

Transplant Patients.

To accommodate the high one-time cost of a transplant, CMS will make payments over three months to cover the transplant and immediate subsequent services. CMS calibrated the payments by using fee-for-service hospital stay payments for the transplant, and physician and other services rendered for the hospital stay and the two months after discharge. The national average was converted to a relative factor by dividing by the national average payment for dialysis patients. The transplant factor is applied to the state ratebook for dialysis to convert back to a transplant payment. Transplant payments, thus, have geographic adjustments. Payment will be made in practice by determining the month of transplant and paying the amount over the three-month period starting the transplant month.

The simplest method of paying the total amount would be to divide the total factor by three and pay in equal parts. For example, assuming that the national average three-month program cost for a transplant is \$40,000 and that the national average monthly cost for a dialysis patient is \$3,500, the relative factor would be 3.81 (i.e., $[40,000/3]/3500$). Payments for a transplant for an average ESRD enrollee would be $3.81 \times 3,500 = \$13,335$ for each of the three months. Payments in higher or lower cost areas would vary.

By examining data from 2002, when a new DRG was added that clearly specified payment for a kidney/pancreas simultaneous transplant, CMS has been able to determine

a differential payment for the two transplant types. Each type will have a different factor. However, because the initial data system used for payment will not be able to distinguish the double transplant timely, all transplants will initially be paid at the kidney transplant rate. The rarer double transplant will be taken into account in reconciliation.

Functioning Graft Beneficiaries.

The model for functioning graft enrollees is based on the model for the general population, except that HCCs for kidney transplant status, dialysis status and renal failure are excluded. For their members with functioning grafts, as for dialysis members, MA organizations will be paid in 2005 based on the diseases reported from all sources in the prior year. However, functioning graft status is recognized in the payment year. In the adapted general population model almost all of the HCC disease coefficients have been held to their general population values. A few HCCs have been removed and extra terms have been added specific to being in functioning graft status. The values for the add-on terms have been estimated with data specific to this population and recognize the Medicare coverage of immunosuppressive drugs and the added intensity of services required by this population.

The functioning graft payment automatically begins the month after the third transplant payment unless CMS hears from the MA organization or the CMS data system that the member has returned to dialysis. Anytime a functioning graft patient returns to dialysis, payment is made using that model.

Since Section 605 of BIPA required CMS to adjust our approach to computing ESRD payment rates to reflect the method used in the ESRD Social HMO (S/HMO) demonstration then in place, we interpret this to mean that the new three-part model will be implemented at 100 percent of payments for 2005, just as the 2002 changes to the ESRD methodology per BIPA were implemented at 100 percent.

New Enrollee Factor.

The dialysis and functioning graft models will have new enrollee factors for enrollees whose risk scores are not available. See Exhibit 1 for the draft coefficients.

Reporting of ESRD Status.

In moving to the implementation of the new ESRD risk adjustment method, CMS will utilize the existing systems for identification of enrollees receiving dialysis services. Currently, MA enrollees are assigned ESRD status as a result of a physician certifying their ESRD status on CMS Form 2728, the End Stage Renal Disease Medical Evidence Report. The ESRD facility sends Form 2728 to the Renal Network, which then transmits the status to CMS systems where various databases are updated to record the ESRD status. Payments for dialysis are triggered by this system.

The ESRD information system would also remain the standard for identifying enrollees who received a transplant. However, MA organizations would be given the opportunity to notify CMS directly of a transplant in order to receive more timely payments for a transplant. Ultimately, MA organization-reported ESRD status will be reconciled against

CMS's existing ESRD information reporting system to determine final ESRD status for payment. CMS will provide additional information to plans regarding direct notification of a transplant in early fall.

D. CMS-HCC Model Implementation Issues

1. Transition Payment Blends

For MA organizations and specialized MA plans, in 2005 the CMS-HCC model will be applied at 50 percent risk adjusted payment, with the remaining 50 percent being a demographic payment. The EverCare demonstration is scheduled to end December 31, 2004. If the project is extended, the same 50/50 blend will apply to EverCare in 2005, but the non-risk adjusted portion of the payment will be based on their 2003 payment methodology rather than the demographic payment.

For PACE organizations, in 2005 the CMS-HCC model with a supplemental frailty adjuster will be applied at 30 percent risk adjusted payment, with the remaining 70 percent being based on the 2003 PACE payment methodology.

The current Social HMO (S/HMO) demonstration expires on December 31, 2004. Pending a decision on the extension of the S/HMO demonstration, in 2005 we intend to apply the CMS-HCC risk model with a supplemental frailty adjuster at 30 percent risk adjusted payment, with the remaining 70 percent based on the S/HMO 2003 payment methodology. The current waiver for the Minnesota Senior Health Options (MSHO) and the Minnesota Disability Health Options (MnDHO) demonstrations expire on December 31, 2004. Pending a decision on the extension of the waivers, we intend to apply the CMS-HCC model with a supplemental frailty adjuster at 30 percent risk adjusted payment in 2005. The remaining 70 percent will be based on the 2003 payment methodology for MSHO/MnDHO. The CMS-HCC model with a supplemental frailty adjuster will also be applied to the Wisconsin Partnership Program (WPP) demonstration and the Massachusetts Senior Care Options demonstration in 2005, with 30 percent being risk adjusted payment and 70 percent based on the 2003 WPP payment methodology.

(See Exhibit 2 for a summary chart of payment blends).

2. Budget Neutrality.

In 2005, risk adjustment will continue to be implemented in a budget neutral manner. CMS will estimate the amount of adjustment to be applied to the rescaling factor, which for 2005 redistributes estimated payment reductions that would result if risk adjustment were implemented without budget neutrality. The estimate is the difference between the aggregate MA payment that would be made using the demographic-only method for 100 percent of payments versus the aggregate payments that would be made using 100 percent of risk adjusted payments. The budget neutrality estimate is a multiplier applied to the rescaling factor.

Because the budget neutrality estimate is subject to change, CMS is considering technical improvements to the budget neutrality estimation methodology in order to improve the

accuracy of payments based on this estimate. We are considering a trend analysis to adjust the estimate. This approach would adjust our current methodology to consider the effect of certain factors. These factors include: changes in average organization level risk scores due to death and disenrollment; the effect of using non-lagged risk adjustment data in the budget neutrality estimate; and the effect of the increase in risk scores because data are submitted for a data collection period (a 12 month period) after the budget neutrality estimate has been calculated for that year. (Note: non-lagged data is defined as using diagnoses from the calendar year immediately preceding the payment year, while lagged data moves the data collection period back 6 months (to a July to June data collection period).) This approach would require analyzing the trends in these factors and adjusting for them. Some of the factors would have the effect of lowering the budget neutrality estimate (i.e., risk scores for a plan would rise because more data were submitted), while others would raise the estimate (risk scores for a plan would be lower due to deaths and disenrollment). We invite comments on this approach.

MA organizations will be required to reflect budget neutrality payments for 2005 in their 2005 Adjusted Community Rate Proposals (ACRPs). The ACRPs for 2005 are due by statute in September 2004. MA organizations will see payments that reflect this budget neutral approach in the beneficiary-level amounts that are shown on the Monthly Membership Reports (MMR). The reports for January 2005 will be available for downloading in late December 2004.

3. Updating Diagnoses Codes in the Model

CMS will update the CMS-HCC risk adjustment model to reflect the annual updates to the ICD-9 diagnostic code set. After clinical review, new ICD-9 diagnosis codes will be added to the appropriate diagnostic category and included in the CMS-HCC model. Organizations will be informed of the new diagnostic codes to be collected and submitted via an announcement in HPMS.

Attachment II

Preliminary Estimate of the National Per Capita Growth Percentage for Calendar Year (CY) 2005

As discussed in Attachment I, the MMA provides that, in years like 2005 when we are rebasing FFS rates, payment will be based on the higher of 100 percent of FFS or a minimum percentage increase of the higher of two percent or the Medicare growth percentage, with no adjustment to this percentage for over- or under-estimates for years before 2004.

The current estimate of the change in the national per capita MA growth percentage for aged enrollees in CY 2005 is 6.6 percent. This estimate reflects an underlying trend change for CY 2005 in per capita costs of 6.1 percent and an adjustment for the fact that the current estimate of CY 2004 aged MA growth percentages is 0.5 percent higher than

the estimates actually used in calculating the revised CY 2004 capitation rate book that was published January 16, 2004 (as required by Section 1853(c)(6)(C) of the Act).

The following table summarizes the estimates for the change in the national per capita MA growth percentage, which will be used for the minimum percentage increase.

National Per Capita Growth Percentage

	Aged	Disabled	ESRD	Aged+Disabled
2005 Trend Change	6.1%	6.2%	5.4%	6.1%
Revision to CY 2004 Estimate	0.5%	0.6%	0.5%	0.5%
Total Change	6.6%	6.8%	5.9%	6.6%

Note: The above percentages are multiplicative not additive.

These estimates are preliminary and could change before the final rates are announced on May 10, 2004. Further details on the derivation of the national per capita MA growth percentage will also be presented in the May 10 announcement.

EXHIBIT 1. DRAFT CMS-HCC DIALYSIS MODEL

Draft CMS-HCC Dialysis Model¹

Risk factors are relative to average total Medicare expenditures per capita for dialysis patients

Mean Year 2000 Total Expenditures=\$52,392

<u>Variable</u>	<u>Label</u>	<u>Relative Factor</u>
<u>Age/Sex Groups</u>		
MC0_34		0.648
MC35_44		0.654
MC45_54		0.676
MC55_59		0.723
MC60_64		0.719
MC65_69		0.775
MC70_74		0.786
MC75_79		0.806
MC80_84		0.832
MC85_GT		0.873
WC0_34		0.719
WC35_44		0.722
WC45_54		0.743
WC55_59		0.735
WC60_64		0.756
WC65_69		0.826
WC70_74		0.848
WC75_79		0.863
WC80_84		0.869
WC85_GT		0.919
<u>Disease Groups</u>		
HCC1	HIV/AIDS	0.174
HCC2	Septicemia/Shock	0.075
HCC5	Opportunistic Infections	0.070
HCC7	Metastatic Cancer and Acute Leukemia	0.161
HCC8	Lung, Upper Digestive Tract, and Other Severe Cancers	0.161
HCC9	Lymphatic, Head and Neck, Brain and Other Major Cancers	0.149
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors	0.047
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation	0.106
HCC16	Diabetes with Neurologic or Other Specified Manifestation	0.106
HCC17	Diabetes with Acute Complications	0.106
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation	0.106
HCC19	Diabetes without Complication	0.106
HCC21	Protein-Calorie Malnutrition	0.073
HCC25	End-Stage Liver Disease	0.113

HCC26	Cirrhosis of Liver	0.100
HCC27	Chronic Hepatitis	0.035
HCC31	Intestinal Obstruction/Perforation	0.061
HCC32	Pancreatic Disease	0.075
HCC33	Inflammatory Bowel Disease	0.100
HCC37	Bone/Joint/Muscle Infections/Necrosis	0.135
HCC38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.092
HCC44	Severe Hematological Disorders	0.096
HCC45	Disorders of Immunity	0.058
HCC51	Drug/Alcohol Psychosis	0.030
HCC52	Drug/Alcohol Dependence	0.030
HCC54	Schizophrenia	0.116
HCC55	Major Depressive, Bipolar, and Paranoid Disorders	0.116
HCC67	Quadriplegia, Other Extensive Paralysis	0.260
HCC68	Paraplegia	0.260
HCC69	Spinal Cord Disorders/Injuries	0.090
HCC70	Muscular Dystrophy	0.076
HCC71	Polyneuropathy	0.050
HCC72	Multiple Sclerosis	0.076
HCC73	Parkinson's and Huntington's Diseases	0.037
HCC74	Seizure Disorders and Convulsions	0.067
HCC75	Coma, Brain Compression/Anoxic Damage	0.072
HCC77	Respirator Dependence/Tracheostomy Status	0.199
HCC78	Respiratory Arrest	0.181
HCC79	Cardio-Respiratory Failure and Shock	0.066
HCC80	Congestive Heart Failure	0.082
HCC81	Acute Myocardial Infarction	0.091
HCC82	Unstable Angina and Other Acute Ischemic Heart Disease	0.091
HCC83	Angina Pectoris/Old Myocardial Infarction	0.034
HCC92	Specified Heart Arrhythmias	0.066
HCC95	Cerebral Hemorrhage	0.059
HCC96	Ischemic or Unspecified Stroke	0.059
HCC100	Hemiplegia/Hemiparesis	0.082
HCC101	Cerebral Palsy and Other Paralytic Syndromes	0.063
HCC104	Vascular Disease with Complications	0.141
HCC105	Vascular Disease	0.057
HCC107	Cystic Fibrosis	0.074
HCC108	Chronic Obstructive Pulmonary Disease	0.074
HCC111	Aspiration and Specified Bacterial Pneumonias	0.118
HCC112	Pneumococcal Pneumonia, Emphysema, Lung Abscess	0.042
HCC119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.038
HCC148	Decubitus Ulcer of Skin	0.177
HCC149	Chronic Ulcer of Skin, Except Decubitus	0.111
HCC150	Extensive Third-Degree Burns	0.084
HCC154	Sever Head Injury	0.072
HCC155	Major Head Injury	0.039
HCC157	Vertebral Fractures without Spinal Cord Injury	0.047
HCC158	Hip Fracture/Dislocation	0.051

HCC161	Traumatic Amputation	0.094
HCC164	Major Complications of Medical Care and Trauma	0.027
HCC174	Major Organ Transplant Status	0.171
HCC176	Artificial Openings for Feeding or Elimination	0.073
HCC177	Amputation Status, Lower Limb/Amputation Complications	0.094
<u>Medicaid Interactions with Age and Sex</u>		
MEDICAID_FEMALE_AGED		0.035
MEDICAID_FEMALE_DISABLED		0.051
MEDICAID_MALE_AGED		0.049
MEDICAID_MALE_DISABLED		0.042
<u>Originally Disabled Interactions With Sex</u>		
ORIGESR_FEMALE	65+, Originally Entitled due to ESRD/ w or wo Disability	-0.069
ORIGESR_MALE	65+, Originally Entitled due to ESRD/ w or wo Disability	-0.052
ORIG1_FEMALE	65+, Originally Entitled due to Disability (non-ESRD)	0.050
ORIG1_MALE	65+, Originally Entitled due to Disability (non-ESRD)	0.023
<u>Disabled/Disease Interactions</u>		
D_HCC5	<65*Opportunistic Infections	0.083
D_HCC44	<65*Severe Hematological Disorders	0.065
D_HCC51	<65*Drug/Alcohol Psychosis	0.087
D_HCC52	<65*Drug/Alcohol Dependence	0.087
D_HCC107	<65*Cystic Fibrosis	0.185

¹This model is used for those enrollees who have a full year of base year claims data.

EXHIBIT 2. SUMMARY CHART OF TRANSITION PAYMENT BLENDS FOR RISK/FRAILITY ADJUSTMENT IN 2005

	Risk adjustment with a frailty adjuster?	Transition Blend- representing the percentage of demographic (or 2003 payment methodology) versus risk adjusted payment to be used in 2005
Medicare Advantage (MA) organizations	No, risk adjustment only	50/50%
Specialized MA plans	No, risk adjustment only	50/50%
Evercare	No, risk adjustment only	50/50%
Program of All-inclusive Care For the Elderly (PACE)	Yes	70/30%
Wisconsin Partnership Program (WPP)	Yes	70/30%
Minnesota Senior Care Options (MSHO) and Disability Health Options (MnDHO)	Yes	70/30%
Massachusetts Senior Care Options	Yes	70/30%
Social Health Maintenance Organizations (S/HMOs)	Yes	70/30%