MEMORANDUM

Subject: Summary of Rationale for Maintaining Key Differences between CMS's Payment-Standardized Total Per Capita Cost Measure for Medicare Fee-for-Service (FFS) Beneficiaries and HealthPartners' Total Resource Use Population-Based Per Member Per Month Index (#1598) Measure

From: CMS and HealthPartners

Date: April 11, 2013

Introduction

The National Quality Forum (NQF) requested that the Centers for Medicare & Medicaid Services (CMS) and HealthPartners identify areas where harmonization may be possible and provide a rationale for maintaining key differences between their respective total per capita resource use measures. In January 2012, NQF endorsed HealthPartners' Total Resource Use Population-Based Per Member Per Month Index (#1598). Although the HealthPartners measure and CMS's Payment Standardized Total Per Capita Cost Measure for Medicare Fee for Service (FFS) Beneficiaries both focus on total per capita resource use, the CMS measure is designed specifically for the Medicare FFS beneficiary population, while the HealthPartners measure is designed and endorsed for the commercially insured (fully insured and self insured) population. There are important differences in the target populations that preclude CMS and HealthPartners from merging or "harmonizing" our measures. The distinctions between the measures' target populations require necessary differences in risk adjustment, pharmacy data inclusion, payment standardization, and attribution methods. As we discuss below, we believe that these important differences require two distinct measures, one for the commercial population and one for the Medicare population, because no single measurement approach would produce valid and reliable results or be actionable for end users.

Target Population

The CMS and HealthPartners measures differ meaningfully in terms of their purposes, testing and calibration, and characteristics of their target populations. CMS specifically developed its measure to evaluate Medicare FFS beneficiaries to help assess, when combined with quality metrics, the value of care provided to Medicare FFS beneficiaries by medical group practices; all testing, therefore, has been performed on the Medicare FFS beneficiary population only. By contrast, HealthPartners specifically designed and tested its measure to be used in conjunction with quality measures to assess value for a commercially insured population. Medicare beneficiaries tend to be older than commercially insured consumers, and they have greater and vastly different health needs: in 2010, more than two-thirds of Medicare beneficiaries had two or more chronic conditions, and the number of beneficiaries with multiple chronic conditions increased with age.[1] By comparison, the share of commercially insured patients with multiple chronic conditions is much lower, at roughly 15 percent.[2] Medicare beneficiaries with multiple chronic conditions are more likely to have been hospitalized and have post-acute services, home health visits, emergency department visits, and doctor office visits than beneficiaries with at most one chronic condition.[3]

Given the differences in the populations on which the two measures have been evaluated, the measures' methodologies necessarily differ, so the two populations' measurement results should not be combined.

CMS and HealthPartners recommend maintaining the distinct target populations for which their measures were designed, rather than harmonizing by expanding the target population of one measure or the other.

Risk Adjustment Methodologies

Per NQF's Guidance for Measure Harmonization,[4] risk adjustment methodologies are not currently recommended areas for measure harmonization. CMS and HealthPartners agree that harmonization of risk adjustment between the Total Resource Use Population-Based Per Member Per Month Index and the Payment-Standardized Total Per Capita Cost Measure for Medicare FFS Beneficiaries is not advisable. The HealthPartners measure uses a commercial risk adjustment methodology developed and calibrated specifically for the commercially insured population (and not for Medicare): namely, Johns Hopkins University's Adjusted Clinical Groups (ACG) Case Mix System.[5] The CMS measure, with its focus on Medicare FFS beneficiaries, employs the CMS Hierarchical Condition Category (CMS-HCC) risk adjustment methodology, which was specifically designed for, tested on, and calibrated to the health status and disease severity of Medicare FFS beneficiaries. CMS considered other risk adjustment methodologies but ultimately selected the CMS-HCC model for risk adjustment in Medicare because of its transparency, ease of modification, and clinical coherence.[6] In its 2011 evaluation of the CMS-HCC risk adjustment methodology, RTI found that the model is effective at predicting actual costs, even for beneficiaries with serious or multiple chronic illnesses.[7] Additionally, the CMS-HCC model is calibrated on the Medicare FFS population. The CMS-HCC risk adjustment methodology effectively captures the detail and nuances of CMS's numerous payment systems and its FFS Medicare population. The ACG approach is appropriate for risk adjustment for a commercial population because it addresses disease prevalence by including maternity, newborn, and other health status indicators that are specific to this population and not found in the Medicare population. For these reasons, CMS and HealthPartners strongly advise against harmonization.

Pharmacy Data

HealthPartners' Total Resource Use Population-Based Per Member Per Month Index includes comprehensive pharmacy data, whereas CMS's Payment-Standardized Total Per Capita Cost Measure for Medicare FFS Beneficiaries does not. CMS and HealthPartners agree that pharmacy data are an important component of resource use and should be included where feasible and appropriate; however, its inclusion is not feasible for the CMS measure because a large percentage of Medicare FFS beneficiaries (over half in 2010) lack Medicare Part D prescription drug coverage. Although some of the beneficiaries lack any prescription drug coverage, the vast majority has prescription drug coverage from a source that is outside of Medicare (e.g., through retiree coverage from a former employer) but for which Medicare does not have access to the data. For the Medicare population, including pharmacy data in the CMS measure could incorrectly indicate higher costs among those beneficiaries with Part D coverage relative to otherwise comparable beneficiaries without Part D coverage and for whom prescription drug costs cannot be measured directly by CMS. Inclusion of pharmacy data in HealthPartners' measure, alternatively, is feasible and should be maintained to estimate total per capita resource use for commercial populations.

For this reason, CMS and HealthPartners recommend that pharmacy data continue to be included in the HealthPartners measure but not in the CMS measure.[*]

Payment Standardization Methodologies

The CMS payment standardization methodology is fundamentally different than the HealthPartners standardization approach. Each approach enhances the accuracy of the respective measures. Although consistent in many respects, they differ significantly due to the varied payment systems addressed by the respective standardization approaches. Consequently, the standardization methodologies do not lend themselves to harmonization.

In essence, the CMS method is a payment standardization methodology used to identify variations in Medicare payment that are attributable to providers' choices in the provision of care to Medicare beneficiaries, including the choice of setting in which that care is provided. In comparison, the standardization approach used in HealthPartners' resource use measure is designed to isolate differences in volume and intensity of services and is calibrated to a commercial population.

Each standardization method determines the relative values of services within and across sectors of care. The weighting across sectors is different for the commercial and Medicare populations, however, because the Medicare average payment rates for each sector are very different from commercial rates. Additionally, standardization for specific settings of care, such as skilled nursing facilities (SNFs), is another area where these measures cannot harmonize their standardization methods, again because Medicare and commercial payment methods differ due to differences in their populations' healthcare utilization patterns and needs. Blending the Medicare and commercial weightings would reduce each measure's effectiveness, accuracy, and reliability.

Medicare also has a wide variety of unique payment systems that do not have parallels in the commercial market. CMS's methodology accounts for the myriad payment systems invoked in Medicare reimbursement and the many special cases in Medicare payment rules in order to characterize relative prices for Medicare services more accurately.[8,9] For example, CMS's approach uses Resource Utilization Groups relative weights to standardize SNF payments. While SNF is not a large factor in commercial claims, it is a significant cost driver for Medicare, and it is important that CMS account for Medicare's unique SNF payment system. A similar approach is used for home health. The CMS model also explicitly accounts for several Medicare FFS-specific payment systems, each with their own unique weighting schemes and values. The HealthPartners measure includes a standardized approach for all of these unique situations as well, but they are calibrated to a commercial population.

As referenced above, pharmacy data is not included in the CMS measure. However, HealthPartners' measure includes pharmacy data and a pharmacy standardization process that is based on resources per day by NDC code, which allows the resource use measure to distinguish between the intensity and quantity of pharmacy usage on total cost of care. The inclusion of pharmacy data also plays a significant role in the relative resource value placed on each sector of care for the purposes of the HealthPartners' standardization method.

[*] We view this position as consistent with NQF's guidance on carve-out arrangements. The National Quality Forum. "National Voluntary Consensus Standards for Cost and Resource Use: Final Report." Washington, D.C.: NQF, April 2012.

Additionally, the HealthPartners' measure includes targeted areas of calibration that highlight variance in resource use consumption that might otherwise be masked, whereas the CMS methodology deliberately retains differences in resource use associated with choice of care setting. For example, within the inpatient setting, to align resources assigned with actual resources consumed, the HealthPartners approach uses the admission length of stay (as well as the MS-DRG) as a factor in resource assignment, so that admissions with longer lengths of stay within the same MS-DRG are assigned more resources. The CMS methodology, on the other hand, uses a bundled inpatient payment, since the true cost to Medicare does not vary with length of stay, except in special circumstances. Under the HealthPartners method, services that can be performed in either professional or outpatient settings, such as imaging and labs, or outpatient surgeries, which can take place in the outpatient hospital or freestanding surgery center, are assigned the same resources because the services that are performed are either identical or can be performed in either setting. The CMS methodology does not equalize across sites of service, in order to measure the costs associated with the choice of treatment location.

In summary, the CMS method is a payment standardization approach based on the CMS payment system, whereas the HealthPartners resource use measure is designed to isolate differences in volume and intensity of services and is calibrated to a commercial population. Given the substantial differences in populations and payment systems associated with the two measures, employing a common standardization method would diminish each measure's effectiveness at producing accurate, valid, and reliable results and would limit their usability either to the Medicare program or to the commercial market.

Attribution

The HealthPartners and CMS measures take different approaches to attribution. Whereas HealthPartners presents their approach as a guideline for measure implementers, the CMS attribution rule is an important component of the CMS measure specification because CMS intends to use the measure as a component of the Value-Based Payment Modifier. Also, and of significant importance, CMS has explicitly chosen to align its attribution methodologies across a number of key and related CMS initiatives, including the Medicare Shared Savings Program and the Medicare Physician Value Program. CMS and HealthPartners therefore recommend retaining their separate approaches to attribution.

Conclusions

CMS and HealthPartners believe that their measures differ in important ways, stemming from differences in the target populations and data sources. The health care needs and utilization patterns of Medicare FFS beneficiaries differ from those of the commercially insured population, and the risk adjustment and standardization methodologies employed by the two measures have been specifically designed to apply to their respective distinct target populations. Given the fundamental differences between ACGs and HCCs, harmonization in this area would lead to inaccurate results for either measure. Additionally, substantial differences in the standardization methodologies reflect the underlying differences in the payment structures and healthcare needs between the commercial and Medicare populations; thus, harmonization on the standardization methodology would undermine the accuracy or usability of either measure. Finally, the attribution approach used in CMS's measure reflects objectives that are specific to the Medicare FFS program and spans multiple agency initiatives. The Payment-Standardized Total Per Capita Cost Measure for Medicare FFS Beneficiaries provides valuable information to medical group practices

through the Medicare FFS Physician Feedback Reporting and will be integral to the calculation of the Value-Based Payment Modifier as mandated by the Affordable Care Act. HealthPartners' measure plays a critical role in understanding resource use in a meaningful way to inform practice redesign and support payment reform in the commercial market. Thus, CMS and HealthPartners agree that measure harmonization would undermine current efforts to accurately measure and report on resource use for our respective target populations and participating providers.

Sincerely,

\s John Pilotte
Director, Performance-Based Payment Policy Group
Centers for Medicare & Medicaid Services

\s Sue Knudson
Vice President, Health Informatics
HealthPartners

[1] Centers for Medicare and Medicaid Services. "Chronic Conditions among Medicare Beneficiaries, Chartbook, 2012 Edition." Baltimore, MD: Centers for Medicare and Medicaid Services, 2012. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf. Accessed March 20, 2013.

[2] The Henry J. Kaiser Family Foundation. "A Profile of Health Insurance Exchange Enrollees." Publication No. 8147. Menlo Park, CA: Kaiser Family Foundation, March 2011. Available at: http://www.kff.org/healthreform/upload/8147.pdf . Accessed March 20, 2013.

[3] Centers for Medicare & Medicaid Services. "Chronic Conditions among Medicare Beneficiaries, Chartbook, 2012 Edition." Baltimore, MD: Centers for Medicare & Medicaid Services, 2012. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf. Accessed March 20, 2013.

[4] The National Quality Forum. "Guidance for Measure Harmonization: A Consensus Report." Washington, D.C.: NQF, 2010. Available at: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=62381. Accessed March 20, 2013.

[5] The Johns Hopkins University. "The Johns Hopkins ACG® System." Available at: http://acg.jhsph.org/index.php?option=com_content&view=article&id=46&Itemid=366. Accessed March 20, 2013.

[6] Pope, G., J. Kautter, R.P. Ellis, A.S. Ash, J.Z. Ayanian, L.I. Iezzoni, M. J. Ingber, J.M. Levy, and J. Robst. "Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model." *Health Care Financing Review*, vol. 25, no. 4, summer 2004, pp. 119-141. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/04summerpg119.pdf. Accessed March 20, 2013.

[7] Pope, G.C., J. Kautter, M.J. Ingber, S. Freeman, R. Sekar, and C. Newhart. "Evaluation of the CMS-HCC Risk Adjustment Model: Final Report." Baltimore, M.D.: Centers for Medicare & Medicaid Services, March 2011. Available at: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Evaluation_Risk_Adj_Model_2011.pdf. Accessed March 20, 2013.

[8] Centers for Medicare & Medicaid Services. "Detailed Methodology for the Total Per Capita Cost Measure for Medicare Fee-For-Service Beneficiaries." Baltimore, M.D.: Centers for Medicare & Medicaid Services, February 2013. Available at: http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Detailed_Methods_Total_Per_Capita_Costs_2-12-13.pdf. Accessed March 20, 2013.

[9] Centers for Medicare & Medicaid Services. "PDAG Standardization Methodology For Allowed Amount—v.2." Baltimore, M.D.: Centers for Medicare & Medicaid Services, January 2012. Available at: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350. Accessed March 20, 2013.