March 7, 2014

Mr. Jonathan Blum
Principal Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Mr. Richard Coyle
Acting Director, Parts C and D Actuarial Group
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: *Advance Notice of Methodological Changes for Calendar Year 2015 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter*

Dear Mr. Blum and Mr. Coyle:

On behalf of the American Medical Group Association (AMGA), we appreciate the opportunity to comment on the above-referenced Advance Notice. AMGA is very concerned about the anticipated 2015 cuts to the Medicare Advantage (MA) program, which compound the scheduled -6.7 percent cuts that MA plans are receiving for calendar year 2014. The totality of cuts, if implemented as proposed, may ultimately serve to decrease beneficiary access to providers and services, and increase costs to beneficiaries enrolled in MA plans.

AMGA represents some of the country's largest, most prestigious integrated health care systems and multi-specialty medical groups. The nearly 130,000 physician practicing within AMGA member medical groups deliver health care services to more than 130 million patients in 49 states, and include such distinguished groups as the Mayo Clinic, Cleveland Clinic Foundation, Ochsner Clinic Foundation, Johns Hopkins University School of Medicine, Geisinger Health System, Henry Ford Health System, and the Permanente Federation. Several of our member medical groups and health care delivery systems have their own MA plans, or treat patients who are MA beneficiaries, and program enrollees are increasing, given the popularity of the MA program. We are therefore concerned about the cumulative impact of the cuts required by statute, but also the policy changes that the Centers for Medicare and Medicaid Services (CMS) is proposing in the Advance Notice.

Multi-specialty medical groups invest in sophisticated information technology, care management processes, and teams of providers to coordinate high quality care. MA plan benefit structures align well with medical groups' provision of outstanding care. However, that care becomes more problematic

when MA reimbursements are significantly reduced for two successive years. Plans and providers will have little recourse except to reduce services and programs for their patients, sacrificing the benefits of these services along the way, such as better management of chronic conditions that result in healthier beneficiaries and reductions in avoidable hospitalizations.

MA plans are also popular with beneficiaries because they provide incentives for them to take active roles in maintaining their own health and wellness, yet thousands of MA beneficiaries have already experienced a disruption in their health plan due to the 2014 rate cuts because their plans were forced out of the insurance marketplace. This trend will only continue in 2015, and is obviously not in the best interests of MA beneficiaries.

We recognize that some of these provisions that having an impact on payment to MA plans are required by the Affordable Care Act, such as the new methodology for calculating benchmarks in each MA county rate, and the changes related to risk adjustment. We urge CMS to mitigate to the extent possible, through its considerable administrative discretion, the impact of these changes to minimize the disruption to the MA program.

Public Comment Process

Before further discussion on specific provisions, we would like to comment more broadly on the public comment process for this Advance Notice, and the extremely short timeframe provided to stakeholders to submit comments. The Advance Notice is a very detailed document that outlines numerous provisions affecting both payments and policies for MA plans. Thorough analysis of the impact of these provisions requires plans to pull together the input of their clinical, quality, and financial staffs, and in a hurry. Several AMGA member medical groups have commented that a two-week timeframe is simply not sufficient to gain a thorough understanding of the impact of the proposals in the Advance Notice. This deadline also coincides with the comment period deadline on another MA proposed regulation concerning policy and technical changes for 2015, due the same day. In the future, we request that CMS consider providing more time for stakeholders to respond to the proposals found in the Advance Notice.

MA Enrollee Risk Assessments in the Home

Of particular concern to MA plans is the proposal to exclude, for risk adjustment purposes, the diagnoses collected from MA enrollee risk assessments that are conducted in beneficiaries' homes that are not later confirmed by a subsequent clinical encounter, due to concerns that the information collected during these visits may not be used to improve the treatment of beneficiaries. However, we believe that the home is and should be considered a clinical setting, and be acknowledged as such by CMS, since home visits ensure that clinicians can follow patients with high disease burden who may not seek care on their own until their situation requires treatment in an emergency setting. Proper follow-up and treatment for patients is the standard of care, and a benefit to the patient, whether furnished in the home or a clinical setting. Further, documentation of a plan of care is a required element for a Hierarchical Condition Category (HCC) code upon chart review in order to be compliant. We also note

that the CMS proposal does not distinguish between home visits supervised by a medical group, and those done by a health plan. Home visits conducted by physicians and their care teams gather important information, including the performance of lab tests, that becomes part of the medical record and informs care coordination and the development of care plans. Such visits can also include fall prevention strategies and other causes of hospitalization.

Moreover, this proposal does not appear consistent with the direction that CMS is heading with respect to services furnished through Medicare Part B. CMS has recognized the importance of care provided to beneficiaries with chronic illness through phone visits, patient portal tools, and even e-mail. These services support beneficiaries at critical times and contribute to care coordination and a decrease in avoidable hospitalizations.

Finally, CMS has tools in place that address perceived coding differences between MA and Part B, such as the coding intensity adjustment factor, which will increase in 2015. CMS is also in the process of implementing a new risk adjustment model that is changing coefficients on some diagnoses to reflect changes in the relative costs of care. A further downward adjustment through the proposal to exclude home visit diagnoses represents an over-correction, and we urge the agency to rethink this proposal.

Part C Services Via Remote Access Technologies

We are pleased that CMS is requesting comment and soliciting proposals to develop policies on remote access technologies in the MA program. Physician groups participating in MA plans are in an ideal position to pilot expansions in technologies for remote access that go beyond services to rural beneficiaries because these groups are already accountable for quality, access, and beneficiary experience of care. Many medical groups and health care delivery systems are offering telehealth services to their commercial and Medicaid populations, and they are well-positioned to offer similar services to Medicare patients who are often less mobile and face more hardships in getting to the physician's office.

Some AMGA member medical groups provide options for home monitoring to manage patients with heart failure, or utilize Interactive Voice Recognition (IVR) technology to manage other chronic conditions. Increasingly, medical groups are offering options for telephone visits or online visits, when clinically appropriate. These options help to fill potential gaps in care for patients who are frail or just had surgery, and require close follow-up to prevent hospital readmissions

In closing, we urge CMS to think carefully about how to mitigate the proposed rate reductions for MA plans in 2015, given the potential to disrupt care and limit choices to MA beneficiaries. Thank you for your consideration of our views on the Advance Notice, and please feel free to contact Karen Ferguson at kferguson@amga.org with any questions you may have.

Sincerely,

Donald W. Fisher, PhD, CAE
President and CEO – AMGA