American Medical Group Association®

March 4, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Slavitt:

On behalf of the American Medical Group Association (AMGA), we appreciate the opportunity to comment on the Advance Notice of Methodological Changes for Calendar Year 2017 Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter. Founded in 1950, AMGA represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Our member medical groups are working diligently to provide innovative, high quality, patient-centered medical care in a financially effective manner. Many of our medical groups treat Medicare Advantage beneficiaries. We have a strong interest in the proposed payment and regulatory policy changes in the Medicare Advantage Advance Notice.

2017 Payment Changes

The Centers for Medicare and Medicaid Services (CMS) estimates an expected average change in revenue for plan payments of 1.35 percent after the application of advance notice policies including the MA coding intensity adjustment, re-basing, and a 3 percent effective growth rate. We are generally pleased with this year-to-year percentage change since it will help to continue to improve and grow program participation.

CMS Hierarchical Condition Category Risk Adjustment Model for CY 2017

CMS is proposing to improve the agency's Hierarchical Condition Category (HCC) risk adjustment model in Part C payment for aged/disabled beneficiaries enrolled in MA plans, including dual-eligible beneficiaries. The proposed updates include:

- Updates to the data years used to recalibrate the model;
- Revisions to the community model that replace the single community segment with six separate model segments (non-dual aged, non-dual disabled, full-benefit dual aged, full-benefit dual disabled, partial-benefit dual aged and, partial-benefit dual disabled); each segment would have relative factors that are independently developed for that segment and would reflect the specific relative costs for an HCC for that subgroup;
- Updates to disease interactions; and,
- Updates to the community and long-term institutional (LTI) segments so the community risk score reflects the dual status in the payment month; and the LTI risk scores will include a Medicaid factor based on Medicaid status in the payment year.

The new detailed subgroupings reflecting specific relative costs represent a welcomed advancement in MA risk scoring. AMGA believes this progress needs to be extended to other Medicare programs, particularly the Medicare Shared Savings Program (MSSP). We also are pleased that CMS is "not proposing to make any changes to the model in order to retain the average MA risk score at the same level that it was under the current model." AMGA agrees with CMS that implementation will not be budget neutral.

Encounter Data as a Diagnosis Source for 2017

CMS proposes to continue the agency's transition to Encounter Data System (EDS) risk scoring. Specifically, CMS is proposing to transition from a 90 percent Risk Adjustment Processing System (RAPS) and Fee-For-Service (FFS) and 10 percent EDS to a weighting of 50 percent RAPS and 50 percent EDS. CMS believes this constitutes a "reasonable progression."

AMGA remains concerned that moving toward a more heavily weighted EDS risk score will further exacerbate already existing problems with accurate EDS reporting. For example, in its September 2015 report, "Encounter Data: Issues and Implications for California's Capitated, Delegated Market," the California Integrated Healthcare Association (IHA) concluded, in part, that multiple data handoffs and variation in data collection hamper the exchange of encounter data among contracting parties. IHA observed there are multiple rejection points as data migrates among any and all data intermediaries, such as from the physician to the provider organization and then on to the health plan and purchaser. Data accuracy is critical because there is a positive correlation between reported encounter volume per patient per year and risk scores. In addition, MA plans and providers depend on accurate risk adjusted per-member per-month reimbursement.

For this reason, AMGA requests CMS detail in its final notice what current and planned process improvement or system redesign activities the agency will use to assist MA plans and providers that lend confidence the EDS process is working appropriately. Until a concrete improvement plan has been put in place, AMGA believes that it would be appropriate to delay a move toward risk scoring weighted more heavily toward encounter-based data.

Impact of Socio-economic and Disability Status on Star Ratings

CMS is proposing to implement a new analytical adjustment, termed the Categorical Adjustment Index (CAI), which would add or subtract from a contract's Overall and/or Summary Star Rating to adjust for the average within-contract proportion of dual-eligible, Low Income Subsidy (LIS) and disabled beneficiaries. The proposed adjustment is an attempt to capture plan performance more accurately and will be instituted on an interim basis while the Assistant Secretary for Planning and Evaluation (ASPE) and other measure stewards continue to work toward a more permanent solution.

As stated in our public comments on the 2016 Call Letter, AMGA appreciates the agency's effort to make the Star Ratings program more equitable for plans and providers who have a comparatively larger number of beneficiaries with dual or LIS status. We also support the move away from the 2016 proposal to weigh by half certain Part C measures.

Public Comment Process

We look forward to next year's extension of the public comment process for the Advance Notice. As you are well aware, submitting comments requires a substantial amount of clinical and financial analysis. Providing MA participants and others more time to prepare their response will no doubt improve the MA program. We thank CMS for the thoughtful consideration of our comments. Should you have questions please do not hesitate to contact AMGA's Mr. Garrett Eberhardt at (703) 838.0033 or at geberhardt@amga.org.

Sincerely,

Donald W. Fisher, Ph.D., CAE
President and CEO