AMGA
Advancing High Performance Health

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Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Verma:

On behalf of the AMGA, I appreciate the opportunity to comment on the Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter. Founded in 1950, AMGA represents more than 450 multispecialty medical groups and integrated delivery systems, representing about 177,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide innovative, high-quality, patient-centered medical care in a cost-efficient manner. Many of our medical groups treat MA beneficiaries, and therefore, AMGA has a strong interest in the proposed payment and regulatory policy changes in the MA Advance Notice.

Key Recommendations:

- AMGA strongly supports the expansion of supplemental benefits for those with chronic illnesses and recommends that the Centers for Medicare & Medicaid Services (CMS) provide the flexibility to allow MA plans and providers to work together to ensure as many patients as possible benefit from the newly authorized expansion of benefits.
- AMGA appreciates the need and importance of accurate risk scoring, but is concerned about adding too many conditions to the CMS Hierarchical Condition Category (CMS-HCC) model. AMGA also opposes the further transition to using encounter data as a diagnosis source until this data has been verified.
- AMGA recognizes the severity and toll of the opioid epidemic, but is concerned that the proposed measures to address substance use disorder will impede the appropriate treatment of pain.
- AMGA strongly supports efforts to promote value-based care, but cautions against efforts to include the cost of Part B or Part D drugs in risk-based arrangements, as providers have limited influence on the cost of such drugs.

**Special Supplemental Benefits for the Chronically Ill (SSBCI)**
CMS is proposing to implement a provision of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act that was enacted as part of the Bipartisan Budget Act of 2018. AMGA is a strong supporter of the CHRONIC Care Act and is pleased that

CMS is moving to implement its provisions by proposing an expansion of supplemental benefits to those with chronic diseases. In implementing this benefit, AMGA recommends that CMS take an expansive approach and have MA plans work with providers to ensure as many patients as possible benefit from this expansion of benefits.

To that end, CMS should provide MA plans, in conjunction with their provider partners, as much flexibility as possible in identifying and targeting benefits for chronic diseases, even if they are not listed in the Chapter 16b of the Medicare Managed Care Manual. Limiting the benefit to the conditions identified in the Chapter 16b of the Medicare Managed Care Manual would exclude a number of beneficiaries with chronic conditions who would benefit from the availability of supplemental benefits. For example, Chapter 16b does not include conditions, such as hypertension and rheumatoid arthritis, which are included in the Medicare Advantage Value-Based Insurance Design Model. Furthermore, as noted in the Advanced Notice, CMS ultimately retains authority to approve plans' benefit design, which alleviates any concern that a plan may cover a condition under the expanded SSBCI benefit that does not meet the statutory criteria for inclusion.

CMS also notes that it will convene a technical advisory panel to update the list of chronic conditions that meet the standard for inclusion as a SSBCI. AMGA would be pleased to serve on this committee or assist CMS in identifying an AMGA member to lend its experience as a provider to this panel.

**Implementation of Mandated Changes to the Risk Adjustment Model**

The 21st Century Cures Act requires CMS to update the risk adjustment model to account for the number of conditions an individual enrollee may have. To implement this requirement, CMS is proposing to update the CMS-HCC Risk Adjustment model to include a payment variable related to the number of conditions an individual beneficiary is diagnosed with. CMS first proposed (but did not finalize) how it would implement this requirement in the 2019 Advance Notice through the Payment Condition Count model.

Under this model, a separate factor would be included for the number of conditions. Adjustment would be made to the total predicted cost as the number of conditions increases. CMS is seeking comment on a variation of this model, which would simply add HCCs for pressure ulcers and dementia, which are not in the current risk adjustment model. Regardless of the model that CMS ultimately finalizes, the new model will be phased in over a 3-year period; for 2020, it will be blended with the current risk adjustment model on a 50%-50% basis.

AMGA is generally supportive of the model that CMS has proposed, as it is important to account for the number of conditions that an enrollee has to accurately risk adjust for those patients with multiple chronic conditions. Ensuring that the risk adjustment model accurately accounts for those patients with multiple chronic diseases is vitally important to both MA plans and providers. This is a key aspect of any model of care based on care coordination, and AMGA member providers constantly evaluate their patients to ensure they are receiving the most appropriate care in the correct setting.

In making adjustments to the risk adjustment model to incorporate additional HHCs, CMS must strike a balance between adding additional information to present as complete a picture as possible of the patients' health status and unduly burdening providers. In addition, AMGA agrees with CMS that the emphasis of the risk adjustment model should be on the severity of the

conditions and, as CMS states "not mainly by the number of the conditions" the beneficiary has. Factoring the number of conditions is one aspect of providing as complete a picture as possible of the patient's condition. That caveat aside, CMS' proposal to include HCCs for dementia has merit, as the condition is a significant multiplier on the costs of chronic conditions.[i]

**Use of Encounter Data**

CMS proposes to increase the percent weight attributed to encounter data in calculating MA plan risk scores. This continues the transition from the Risk Adjustment Processing System (RAPS) to the Encounter Data System (EDS) that CMS first initiated in 2016. For 2020, CMS is proposing to use a blend of 50% EDS and 50% RAPS data, up from 25% EDS and 75% RAPS in 2019. AMGA remains concerned about the reliability of using such data to calculate risk scores. As we wrote in response to the 2019 Advanced Notice, "Before continuing this transition, CMS needs to ensure encounter data is accurate, reliable, and verifiable." In January 2018, the Office of Inspector General of the Department of Health and Human Services issued a report that determined that CMS has taken steps to ensure data integrity. However, the report notes that CMS has "not established performance measures that monitor [Medicare Advantage Organizations] submission of records with complete and valid data."

Rather than move forward with the proposal to equally blend EDS and RAPS data, CMS should pause any further progression in the transition until the EDS data is validated.

**Addressing the Opioid Epidemic**

AMGA understands the toll that opioid-related substance use disorder can inflict on patients, their families, and the larger community. AMGA also has supported improving access to naloxone and appreciates that CMS is proposing reforms to improve access to the reversal agent when clinically appropriate. As CMS is aware, states also are considering policies to increase access to naloxone. These efforts, however, should not result in patients facing unnecessary barriers to obtaining appropriate treatments for pain.

CMS is requesting comments on the feasibility of co-prescribing naloxone with concurrent opioid prescriptions. This decision should be left in the hands of physicians, as it may not be warranted or appropriate in each circumstance. While AMGA commends CMS for examining a variety of ways to address this problem and the role that plan benefit design has to play, CMS also must be cautious that the policy does not unduly pressure providers to co-prescribe naloxone. AMGA members are cognizant of the issues surrounding opioids and are working to ensure their patients receive the best, safest,—and most appropriate—care.

**Risk-Based Contracting for Pharmacy Benefits**

CMS is requesting comments on the feasibility of risk-based arrangements for pharmacy benefits in contracts between MA plans and their contracted providers. AMGA and its members are invested in the transition to value-based care and recognize that addressing prescription drug costs is a priority for the Department of Health and Human Services. Part B and Part D prescription drugs, however, are not appropriate for inclusion in risk-based contracts, as prescription drugs, particularly Part B drugs, can be a significant driver of cost and is outside the control of the group practice or physician.

Recent experience with the Merit-based Incentive Payment System (MIPS) demonstrates the difficulty of factoring Part B drug costs in any reimbursement system designed to hold physicians

accountable for the cost and quality of care provided. As originally enacted, the Medicare Access and CHIP Reauthorization Act (MACRA) included the cost of physician-administered drugs in the calculation of MIPS payment adjustments. Part B drugs, however, typically are expensive and have few or no generic alternatives. Most commonly prescribed and provided to treat diseases such as cancer and renal failure, these therapies do not lend themselves to inclusion in a model which is primarily focused on the creative deployment of management practices that help control cost by keeping patients healthy.

In recognition of the lack of influence that physicians have over the price of Part B drugs, Congress revised the MACRA statute as part of the Bipartisan Budget Act of 2018 (BBA of 2018) to explicitly exclude separately billed items—including Medicare Part B drugs—from associated MIPS calculations and payment adjustments.

In the Medicare Shared Savings Program, providers who participate in Accountable Care Organizations are responsible for all Medicare Part A and B costs, including Part B drugs. However, the program truncates an assigned beneficiary's total annual Parts A and B fee-for service (FFS) per capita expenditures at the 99th percentile of national Medicare FFS expenditures as determined for each benchmark year. This effectively excludes patients who require the most expensive treatments, such as those requiring care from the oncology and nephrology specialties, and minimizes the variation caused by catastrophically large claims. AMGA understands that the intent is to encourage providers to modify their Part B prescribing, utilization, and treatment patterns. However, it is the high cost of these drugs that is the underlying issue, which will not be addressed by putting providers at risk.

Including Part D drugs raises similar concerns. Often, Part D drug costs are included in the medical expense ratio (MER) agreement between the MA plan and physician group practices. However, the ratio often is influenced by the rebate that the MA plan receives from a pharmacy benefit manager (PBM). For example, the MER can be adjusted annually based on any rebates the plan receives from the PBM. This process, however, is not transparent. Due to these concerns, AMGA recommends that CMS not include Part D drugs as part of risk arrangements between MA plans and providers, as it puts providers at risk, but does not afford them the opportunity to make a meaningful difference in the cost.

**Additional Comments**

***2019 Payment Change***
AMGA is generally pleased with the proposed 1.59% year-to-year percent change, as it will help to continue to improve the MA program and grow participation.

***Coding Pattern Adjustment***
CMS is proposing to apply the minimum coding pattern adjustment of 5.90%, as required by law. AMGA recommends that CMS finalize this as proposed and implement the statutory minimum coding pattern adjustment.

***Part D Mail Order-Auto Shipping***
CMS is requesting comment on the mail order auto-ship policy. While auto-shipment is an attractive feature for a number of beneficiaries, CMS rightly is concerned about the potential for an oversupply of medication and notes that such a system should account for the possibility of

inappropriate medication accumulation. Such auto-ship programs also need to account for the possibility of a hospitalization or prescriber halting a medication for a period of time. Such a program also needs to account for a possible change in a medication and ensure both providers and patients are aware of any formulary changes.

**Regulatory Timing**

In our comments on the CY 2017 Advance Notice, AMGA noted that CMS provides a very limited time period to analyze and submit comments on the annual MA Advanced Notice. In addition, CMS also has proposed a number of rules that may or may not be final before MA organizations must submit their bids to CMS. For example, AMGA was pleased to submit comments on the 2020 Medicare Advantage and Part D Drug Pricing Proposed Rule (CMS-4180-P), which includes an expansion of telehealth benefits. This policy change, however, needs to be finalized well before plans begin their evaluation of how to structure their bids. CMS should work to align proposals, the comment periods, and the expected final action so that MA organizations and their partners in the provider community have a predictable and consistent regulatory calendar that sets policy for a calendar year well before bids are due.

We thank CMS for consideration of our comments. Should you have questions, please do not hesitate to contact Darryl M. Drevna, AMGA's senior director of regulatory affairs at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer
AMGA

[i] Bynum JP, Rabins PV, Weller W, Niefeld M, Anderson GF, Wu AW. The relationship between a dementia diagnosis, chronic illness, medicare expenditures, and hospital use. J Am Geriatr Soc. 2004 Feb;52(2):187-94.