



March 6, 2015

Mr. Andy Slavitt  
Acting Administrator  
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 (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter

*Submitted Electronically*

Dear Mr. Slavitt:

On behalf of the American Medical Group Association (AMGA), we appreciate the opportunity to comment on the above-referenced Advance Notice. AMGA represents multi-specialty medical groups and other organized systems of care, including some of the nation's largest, most prestigious integrated health care delivery systems. AMGA represents 435 medical groups that employ nearly 160,000 physicians who treat more than 120 million patients. Our member medical groups are working diligently to provide innovative, patient-centered medical care in a cost-effective manner. Many of them are also treating increased numbers of patients who are enrolled in Medicare Advantage (MA), given the growing popularity of the program over the last few years. We therefore have a strong interest in the payment and policy proposals in the 2016 Advance Notice.

#### MA Rate Reduction for 2016

Multi-specialty medical groups, as a whole, are experiencing continual downward pressure on reimbursements, from the cumulative impact of cuts and penalties they are contending with. At the same time, they are increasing the resources devoted to providing high-quality healthcare. Whether it be consecutive cuts to MA, penalty phases for the Physician Quality Reporting System (PQRS) or the Electronic Health Record (EHR) incentive programs, this downward pressure in reimbursements is coming from many fronts, and has a cumulative effect. Given CMS' recent announcement of its substantial goals for increasing value-based purchasing, and Congressional efforts over the past five years to stimulate greater integration and care coordination in the healthcare delivery system, the

constant threat of reductions in MA reimbursements destabilizes an otherwise hugely successful, and popular, healthcare financing model and runs counter to the stated goals of the federal government with respect to incentivizing a high-quality, value-based healthcare delivery system.

Continued reductions in MA will have a negative impact on multi-specialty medical groups and their ability to provide high-quality healthcare to their patients who are enrolled in MA. As medical groups attempt to compensate for these cuts and bring costs in line, a decrease in beneficiary access to plans and providers, and an increase in costs to enrolled beneficiaries, may follow. Multi-specialty medical groups remain at the forefront of the healthcare industry in providing care to individuals who are dually eligible and individuals who receive low-income subsidies. MA is the program best equipped to provide healthcare to these individuals. AMGA therefore urges the agency to use its administrative discretion to keep 2016 MA rates flat to avoid continued disruptions in the MA program and also to best serve those most in need of high-quality, efficient care.

#### CMS-HCC Risk Adjustment Model for CY 2016

For payment year 2016, CMS proposes to transition entirely to using risk scores calculated from the clinically revised 2014 CMS-Hierarchical Condition Categories (HCC) model in Part C payment for MA beneficiaries, after having used a blend of the 2013 model and the 2014 model for 2014 and 2015. AMGA is extremely concerned about the impact of this full transition, given that the new model eliminates diagnosis codes for the early stages of certain high-cost, high-volume disease states. This move seems at odds with the goals of early identification and management of such diseases. MA plans and providers that are effectively managing chronic illnesses in their patient populations should be incentivized for doing so, not have the risk scores of medically complex beneficiaries effectively reduced.

AMGA urges CMS not to finalize its proposal to transition fully to the 2014 CMS-HCC model, which could serve to further erode the ability of medical groups to manage beneficiaries in the early stages of chronic diseases and implement appropriate care management strategies.

#### Value-Based Contracting to Reduce Costs and Improve Health Outcomes

CMS has increasingly taken steps to encourage healthcare providers and payers to operate more efficiently, reduce costs, and improve the health outcomes of patients through incentive programs to reward providers. CMS is also testing a variety of new payment models through the Innovation Center, such as the Comprehensive Primary Care Initiative and bundled payment initiatives. We are pleased to see CMS acknowledge the operational and cultural changes that must take place in order for these new payment models to succeed, in addition to the need to encourage more widespread adoption. To that end, CMS is seeking input from MA organizations to help the agency understand better how to achieve this goal, in order to include them in future MA program policies.

Some attributes that CMS could consider take place in multi-specialty medical groups that employ shared decision-making that is a true collaboration between the patient and their health care providers in addition to conducting quality measurement and improvement activities across sites of care, and between patient visits, to improve the health and outcomes of patient populations. Use of information

technology and evidence-based medicine, where it exists, also contribute to high-quality health care. Use of compensation structures that provide incentives to physicians and licensed and certified medical professionals to improve the health and outcomes of patient populations can help ensure that the provider entity assumes shared financial and regulatory responsibility and accountability for successfully managing costs and quality of care. In order to accomplish these goals, it is necessary to build a leadership team consisting of executives, project managers, EHR experts, quality experts, and clinical experts to plan the work, with goals and objectives being clearly linked to the organizational mission. The culture inherent in this type of healthcare delivery model should support standardization of care processes and collaboration, along with a common vision.

Medical groups and health plans must make significant investments in these areas to achieve the goals of value-based contracting in order to reduce costs and improve outcomes. There currently exists a tremendous opportunity to incentivize healthcare providers to continue along the path to value-based contracting.

#### Star Ratings and Dually Eligible/Low Income Subsidy Beneficiaries

CMS states that multiple MA organizations believe that plans with a high percentage of dual eligible (Dual) and/or low income subsidy (LIS) enrollees are disadvantaged in the current Star Ratings Program, and research into the issue is being conducted internally and with contract-supported entities. CMS also issued a Request for Information (RFI) that provided an opportunity for stakeholders to submit their own analysis and research to demonstrate that dual status causes lower MA and Part D quality measure scores.

The CMS research found some differences in measure-level performance for LIS/Dual beneficiaries, although they were mostly small. CMS believes that additional research into what is causing the differential performance on some of the measures is necessary before any permanent changes are made to the Star Ratings measurement system. However, preliminary analysis indicates differential outcomes for Dual/LIS beneficiaries in the following six Part C measures:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Diabetes Care-Blood Sugar Controlled
- Osteoporosis Management in Women Who Had a Fracture
- Rheumatoid Arthritis Management
- Reducing the Risk of Falling

There is also some evidence of differential outcomes for Dual/LIS beneficiaries for Medication Adherence for Hypertension in Part D.

CMS states that in the long-term it may be appropriate to adjust the Star Ratings where there is scientific evidence that performance on specific measures is affected by patient factors such as comorbidities, disability, or Dual/LIS status. For now, CMS proposes the interim step of reducing the weights on this subset of Part C and Part D measures by half. For the Part C measures, the modified

weight would be 0.5 for 2016 instead of 1, and for the Part D measure, the modified weight would be 1.5 in 2016 instead of 3.

AMGA appreciates the CMS emphasis on making the Star Ratings program more equitable for plans and providers who have a disproportionate share of beneficiaries with Dual or LIS status enrolled in their MA plans, and the proposal to weight by half the Star Ratings for certain measures. Although we recognize that this proposal is an interim measure while more research into the issue is conducted, we are concerned about the potential unintended consequences of such an approach, and suggest that CMS analyze the results of this proposal in 2016 before actual implementation. Unintended consequences could include other Star Ratings measures effectively being more heavily weighted, and inadvertently punishing those plans who are doing very well with the six identified Part C measures, whether they have a disproportionate number of Dual or LIS beneficiaries, or not.

Alternatively, CMS could identify the plans that have a disproportionate number of Dual or LIS patients and direct more resources to those plans, since it can often require more resources to engage individuals who have been classified as Dual or LIS in their own healthcare.

#### Encounter Data as a Diagnosis Source for 2016

CMS proposes to calculate the 2016 risk score by blending two risk scores calculated as follows: one risk-score calculated using diagnoses with dates of service from 2015 Risk Adjustment Processing System (RAPS) and fee-for-service (FFS) and another separate risk score using diagnoses with dates of service from 2015 Encounter Data System (EDS) data and FFS. CMS proposes to blend the two risk scores, weighting the risk score from RAPS and FFS by 90% and the risk score from EDS and FFS by 10%. For PACE organizations, CMS proposes to continue the same method of calculating risk scores as used for the 2015 payment year, which is to use diagnoses from the following sources in equal measure (with no weighting): 1) EDS data valid for risk adjustment with 2015 dates of service, 2) RAPS data valid for risk-adjustment with 2015 dates of service; and 3) diagnoses from FFS claims valid for risk adjustment.

AMGA has concerns about the proposal to include EDS data in risk score calculations, even at a relatively low percentage. It will be difficult for healthcare providers to capture the appropriate data if their electronic health records (EHR) do not have the appropriate fields. This could significantly increase administrative burden, and expense, to ensure that all encounter data is submitted to CMS, given the difficulty in extracting the information if it is not being automatically populated in appropriate fields within an EHR. Moreover, there are concerns about how corrected and denied claims will be processed.

#### Guidance for In-Home Enrollee Risk Assessments

CMS states that over the past few years, they have observed an increase in in-home visits to assess MA enrollees that have been performed by non-physician practitioners employed by downstream contractors, with the comprehensiveness of the assessments, and resulting care plan, being variable. For 2014 and 2015, CMS had proposed to exclude, for payment purposes, diagnoses collected from the enrollee risk assessments that were not confirmed by a subsequent clinical encounter, but did not

finalize the proposal in either case. AMGA shares the CMS concern about individuals who are not part of the healthcare team making in-home enrollee risk assessments. In some cases, MA plans are sending healthcare providers to the homes of MA beneficiaries to provide these assessments, but the clinical information is not being communicated back to the medical group that is responsible for treating the beneficiary. Our members are concerned about a lack of appropriate care coordination when this takes place.

The Advance Notice proposes that in-home assessments be performed by physicians or qualified non-physician practitioners, specifically, advanced practice registered nurses, nurse practitioners, physician assistants or certified clinical nurse specialists. AMGA is in strong agreement with this requirement. The Advance Notices enumerates additional best practices for in-home assessments to include:

- All components of the Annual Wellness Visit, including a health risk assessment such as the CDC model health risk assessment;
- Medication review and reconciliation;
- Scheduling appointments with appropriate providers and making referrals and/or connections for the enrollee to appropriate community resources;
- Conducting an environmental scan of the enrollee's home for safety risks and any need for adaptive equipment;
- A process to verify that needed follow-up is provided;
- A process to verify that information obtained during the assessment is provided to the appropriate plan provider(s);
- Provision to the enrollee of a summary of the information including diagnoses, medications, scheduled follow-up appointments, plan for care coordination, and contact information for appropriate community resources; and
- Enrollment of assessed enrollees into the plan's disease management/case management programs, as appropriate.

While AMGA completely supports patient-centered in-home health risk assessments, and their value in the provision of high-quality healthcare, we urge CMS to ensure that the requirements are not so daunting as to discourage healthcare providers from furnishing this service. The requirements enumerated above may do exactly that. We recommend instead that CMS require that the qualified clinical staff performing in-home risk assessments work for a medical group and follow existing standards of practice to ensure that high-quality, coordinated care is being provided.

We believe that in-home risk assessments are essential in order to prevent certain medically complex patients from falling through the cracks and possibly not receiving needed care. We request careful consideration of how to create a balance between administrative burden and the need for accountability. Engagement strategies to ensure that beneficiaries receive appropriate healthcare could prove to be far more beneficial, and would improve the overall quality and experience of healthcare.

## Public Comment Process

We would also 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 outlining numerous provisions that interact in complex ways to affect payments and policies for MA plans. Thorough analysis of the impact of these provisions requires plans and providers to gather the input of their clinical, quality, and financial staffs, and in a hurry. A two-week timeframe is simply not sufficient to gain a thorough understanding of the impact of the proposals in the Advance Notice. In the future, we request that CMS consider providing more time for stakeholders to respond to these proposals.

CMS has a tremendous opportunity to ensure the continued viability of the MA program in 2016, and all it has to offer in transitioning healthcare delivery to a value-based system, and we request thoughtful consideration of our comments. Should you have questions on any of the comments contained herein, please do not hesitate to contact Karen Ferguson of my staff at [kferguson@amga.org](mailto:kferguson@amga.org).

Sincerely,



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