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March 5, 2018

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

Dear Ms. Verma:

On behalf of the AMGA, we appreciate the opportunity to comment on the 2019 Medicare Advantage Part I Advance Notice – Risk Adjustment and the Advance Notice of Methodological Changes for Calendar Year 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 Draft Call Letter (Part II). 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 work diligently to provide innovative, high quality patient-centered medical care in a spending efficient manner. Many of our medical groups treat Medicare Advantage beneficiaries. AMGA therefore has a strong interest in the proposed payment and regulatory policy changes in the MA Advance Notice.

On balance, AMGA supports several proposals in the 2018 Call Letter. Below are our comment concerning a select few proposed program changes. These do not necessarily appear in priority order.

2018 Payment Change

The Centers for Medicare and Medicaid Services (CMS) estimates an expected average change in revenue for plan payments of 1.84 percent after the application of advance notice policies including a -0.25 percent MA coding intensity adjustment. This excludes an estimated 3.1 percent increase in pay that CMS expects plans to generate by coding more intensely. AMGA is generally pleased with this year-to-year percentage change as it will help to continue to improve the program and grow participation.

Use of Encounter Data

CMS proposes to increase the percent weight attributed to encounter data in calculating Medicare Advantage Organization (MAO) plan risk scores. Specifically, in 2019 CMS proposes to increase the 15 percent – 85 percent Encounter Data System (EDS) and Risk Adjustment Payment System (RAPS) blend to 25 percent use of EDS and 75 percent use of RAPS. However, as noted in earlier comments, AMGA remains concerned about reliability of using such data to calculate risk scores. Before continuing the transition, CMS needs to ensure encounter data is accurate, reliable, and verifiable. As it stands, any further transition or phase-in of encounter data should

be delayed until the issues related to data quality are resolved.

Employer Group Waiver Plans (EGWPs) Payment Rates

In 2016, CMS proposed to terminate the bid process in establishing EGWP payment rates and instead set payments administratively by county. CMS defined administrative price setting by pegging payment rates to the non-employer market. The agency reasoned that because EGWPs do not bid against other plans, they have little incentive to lower bid amounts. Last year CMS chose to freeze the phase-in at 50 percent individual plan bids and 50 percent EGWP plan bids. In 2019, CMS is proposing to use only individual market plan bids. CMS estimates the fully phased policy would amount to a negative 0.3% payment adjustment. CMS is soliciting comments on whether to maintain 2016 formula or the 50 percent – 50 percent blend. CMS is also soliciting comments on whether to calculate bid-to-benchmark (B2B) ratios to account for the difference in the proportion of beneficiaries enrolled in Health Maintenance Organizations (HMOs) versus Preferred Provider Organizations (PPOs). AMGA does not object to the proposed formula change. We do, however, encourage the agency investigate whether or how the difference in the proportional HMO/PPO mix affects pricing.

2019 Star Ratings System

CMS is proposing limited changes to the star rating system. AMGA supports the agency's proposal of two new statin measures: Statin use in persons with diabetes (Part D); and, Statin therapy for patients with cardiovascular disease (Part C). Last year AMGA supported the proposed Beneficiary Access and Performance Problems (BAPP) changes, and we now support the agency's proposal to retire the current BAPP measure. Concerning the changes to the Reducing the Risk of Falling measure or the temporary removal of the measure from star ratings, AMGA supports the modifications or improvements to the underlying survey questions. The draft call letter states the agency “intends” to add the measure back into the star ratings in 2021. Because seniors of any age risk falling it is important they receive timely fall risk interventions from their provider. We strongly encourage CMS to ensure seniors receive fall risk interventions. Finally, AMAGA supports the agency's proposal to score a plan sponsor as non-compliant for a specific data element's data validation via Likert scale scoring and the agency's proposed statistical criteria to reduce a contract's star rating for data that are not complete or lack integrity using data from the Timeliness Monitoring Project (TMP) data or audit (Part II pages 113-114 and page 114, ff).

Supplemental Benefits

Currently qualifying MAOs can provide a supplemental benefit if it is, among other things, primarily health related or if its primary purpose is to prevent, cure or diminish an illness or injury. CMS has not previously approved an item or service as a supplemental benefit if its primary purpose is daily maintenance, such as, fall prevention devices. In the proposed rule, CMS notes it intends to “expand the scope of the primarily health related supplemental benefit standard.”

“Under our new interpretation,” CMS states, “in order for a service or item to be “primarily health related it must diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization. Any supplemental health benefit proposed by an MA organization must be reasonably and rationally encompassed by this standard. This will allow MA plans more flexibility in offering supplemental benefits that can

enhance beneficiaries' quality of life and improve health outcomes." CMS states further, "the primary purpose of an item or service will be determined by national typical usages of most people using the item or service and by community patterns of care. To be considered healthcare benefits, supplemental benefits must focus directly on an enrollee's healthcare needs. Supplemental benefits under this broader interpretation must be medically appropriate and ordered by a licensed provider as part of a care plan if not directly provided by one; supplemental benefits do not include items or services solely to induce enrollment. CMS will issue detailed guidance for MAOs on this issue as they consider upcoming plan offerings.

AMGA agrees with the agency's proposal to expand its definition of "primarily health related."

Improving Drug Utilization Review Controls (Opioids)

CMS outlines several proposed regulatory changes in an attempt to address the opioid crisis. The agency proposes to enhance the Overutilization Monitoring System (OMS) by identifying high-risk beneficiaries using so called "potentiator" drugs, for example, gabapentin and pregabalin, in combination with prescription opioids for the purposes of ensuring there is appropriate case management for these patients. CMS proposes to limit the number of prescribed opioid pills for an initial prescription for acute pain. For example, the initial supply could be limited to seven days, with or without a daily dose maximum. The agency also is proposing soft safety edits, which a pharmacist, whereby sponsors monitor duplicative therapy of multiple long-acting opioids and concurrent opioid prescriptions, can override. Hard formulary level cumulative opioid safety edits are also proposed. These are pharmacy point of sale audits of 90 Morphine Milligram Equivalent (MME) prescriptions with a seven-day supply allowance. The agency is proposing a Pharmacy Quality Alliance (PQA) measure concurrent use of opioids and benzodiazepines (for example, Valium and Xanax), or the percent of individuals with a concurrent use of the medications.

As you know, the Substance Abuse and Mental Health Services Administration (SAMHSA) on February 15 published guidance to on best practices to treat opioid use disorders. AMGA is pleased to see the Department of Health and Human Services is taking a multifaceted approach to confronting the opioid epidemic. While CMS' proposed regulatory and SAMHSA's guidance are welcome, it is also important to balance and policy changes intended to prevent opioid use disorder with needed access to pain medication. As we noted in our September 2016 comments in response to the proposed Hospital Outpatient Prospective Payment rule (CMS-0115-P), under-treatment of chronic pain particularly among minority populations continues to be a major clinical shortcoming.

Although aspects of this epidemic are beyond the scope of healthcare industry, AMGA members remain focused on the appropriate and adequate use of opioids to treat pain and to prevent misuse. At our upcoming conference in Phoenix, several sessions will be dedicated to this topic. AMGA members are acutely aware of this problem and are working to remedy it and share best practices. We are eager to work with CMS and other Health and Human Service operational divisions in combating the epidemic.

Additional Comment: Coding Intensity

Although outside the scope of the Advance Notice, AMGA is taking this opportunity to reiterate its concerns regarding coding intensity. AMGA is pleased CMS proposed to implement the statutory minimum adjustment as required by law for 2019. In its March 2016 report to

Congress, MedPAC again examined MA coding intensity. MedPAC recognized MA plan enrollees have higher risk scores than similar FFS beneficiaries. AMGA recommends CMS consider MedPAC's 2016 recommendation, based on the Commission's 2012 work, that the agency begin using two years of diagnostic data to estimate CMS-HCC model coefficients and two years of MA diagnostic data to calculate MA risk scores. This would improve the accuracy of chronic condition coding by in part mitigating year-to-year variation in documentation and decrease the differences in MA and FFS coding intensity. Implementing this approach would then give CMS the ability to recalculate or reset the coding intensity adjustment should any remaining coding differences remain.

We thank CMS for consideration of our comments. Should you have questions please do not hesitate to contact AMGA's David Introcaso, Ph.D., Senior Director of Public Policy at (703) 842.0774 or at dintrocaso@amga.org.

Sincerely,

A handwritten signature in cursive script that reads "Jerry Penso".

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