Advancing High Performance Health

One Prince Street
Alexandria, VA 22314-3318
O 703.838.0033
F 703.548.1890

March 6, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Brooks-LaSure:

On behalf of AMGA, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.

Founded in 1950, AMGA represents more than 440 multispecialty medical groups and integrated delivery systems, representing about 175,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide high-quality, cost-effective patient-centered medical care.

We are pleased to offer the following recommendations on the CY 2024 Advance Notice. Specifically, we are providing comments on the following:

- **Universal Foundation:** AMGA fully supports CMS' proposed Universal Foundations set and believes that implementing one core set of measures over all CMS value-based programs will significantly reduce the complexity of entering into these programs and, we believe, will greatly increase provider participation.

- **Risk Adjustment Model Changes:** AMGA supports CMS' transition to the International Classification of Diseases, 10th Revision (ICD-10) coding system to increase alignment between CMS programs. However, we urge CMS not to finalize its proposal to revise the diagnoses and condition categories in the Hierarchical Condition Categories (CMS-HCC) model until CMS and all stakeholders understand what the impacts of these changes will mean to MA plan design and provider delivery of care, particularly to patients with chronic conditions.

Our detailed comments are included below.

Universal Foundation Measure Set

Comment: CMS should finalize its proposed Universal Foundations set to increase alignment across value-based programs, promote meaningful quality measures focused

on clinical improvement and patient experience, reduce provider burden, and increase provider participation in value-based programs. This would help facilitate increased provider participation in value-based programs and help to achieve CMS' goal to have 100 percent of Medicare beneficiaries in an accountable care relationship by 2030.

AMGA applauds CMS' interest in improving the effectiveness of quality programs and reducing the burden associated with collecting and reporting quality measures. From a healthcare provider perspective, alignment of not just quality measures, but other aspects of value-based payment arrangements within Medicare and across multiple payers is critical. Indeed, providers often interface with a multitude of payers across Medicare, MA, Medicaid, and commercial insurers and value-based alignment helps to promote meaningful outcomes for vulnerable patient communities.

AMGA has been a strong advocate for increasing alignment across CMS value-based programs for many years. In 2018, AMGA endorsed a streamlined set of quality measures designed to simplify the reporting process and limit the burden on providers and group practices, while still reporting clinically relevant and actionable data.[1] In support of its quality measure endorsement, AMGA established a Quality Measure Task Force that developed a consensus set of measures that are clinically relevant, risk-adjusted, evidence-based, result and improvement focused, patient centered, and statistically sufficient sample sizes. AMGA is pleased CMS is considering a similar approach with its "Universal Foundation" set of quality measures across Medicare programs.

We note similarities between measure selection criteria between AMGA and CMS' universal measure set. For example, Both AMGA and CMS selected the following quality measures for inclusion: Colorectal cancer screening; Breast cancer screening; Hypertension (HTN)/high blood pressure control; HbA1C poor control > 9%; Depression screening; 30-day all cause hospital readmission. Further, we recognize a shared commitment to reducing provider burden through the Universal Measure Set by reducing administrative and financial resources necessary to support quality measure reporting.

Indeed, the Medicare Payment Advisory Commission (MedPAC) observed reporting challenges in its June 2018 to Report to Congress. Specifically, MedPAC then noted Medicare's quality measurement programs are "overbuilt" and rely on "too many clinical process measures that are, at best, weakly correlated with health outcomes of importance to beneficiaries."[2]

Our own members have similarly reported significant cost and resource pressures associated with measure reporting. For example, a 2017 AMGA survey found that for every 100 physicians our members employ, 17 information technology (IT) professionals are needed to support them. These costs are much better spent on caring for patients, not maintaining an expensive IT infrastructure.

---

[1] AMGA Endorses Streamlined Value Measurement Set to Reduce Reporting Burden. AMGA. June 25, 2018. https://www.amga.org/about-amga/amga-newsroom/press-releases/amga-endorses-streamlined-value-measurement-set/

[2] Report to the Congress: Medicare and the Health Care Delivery System. MedPAC. June 2018. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun18_medpacreporttocongress_rev_nov2019_note_sec.pdf

Given AMGA's previous proposal for the adoption of such a measure set, we believe our organization is uniquely positioned to engage with CMS on this issue and would be pleased to meet with the appropriate staff to continue this important work.

Risk Adjustment Model Changes

> **Comment:** CMS should continue its transition to ICD-10; however, the Agency should reconsider the removal of codes from the HCC model, as it may have significant downstream fiscal implications for providers as well as enrollee access to services. CMS should extend the deadline for implementation, and in the meantime, work with stakeholders to project potential impacts on providers and patients prior to removing codes from the HCC model.

For CY 2024, CMS is proposing significant changes to MA risk adjustment methodology. In addition to updating the data years used for model calibration, CMS also is continuing its transition away from ICD-9 to ICD-10. While AMGA supports the broader adoption of ICD-10 for MA, we are concerned about CMS' proposal to implement a revised HCC model with fewer ICD-10-CM codes mapped to an HCC for payment purposes. Specifically, CMS is proposing to remove more than 2000 unique codes from the HCC model. These codes cover a variety of conditions, including, among others, depressive disorder, diabetes with chronic conditions, vascular disease, and rheumatoid arthritis and inflammatory connective tissue disease.

Given the short timeframe to review the change, we are uncertain of the impact this will have on providers in value-based contracts. Participating in value-based programs is challenging: care delivery must change, significant investment in IT and analytics must be made, care managers need to be hired, among many other considerations. Injecting uncertainty into any value-based program acts as a disincentive to both attract and retain value program participants.

1. <u>Short Timeline</u>

Historically, CMS has phased in changes to the MA risk adjustment model to allow plans and providers to adjust their systems and anticipate the potential effects of the changes. However, if finalized as proposed, CMS would not use this approach. Instead, MA plans will need to submit bids based on the new model by June 5, 2023, just four months after CMS released the proposal. This gives providers and plans little time to evaluate the proposal, consider its effects, and provide constructive feedback to CMS by the public comment deadline.

CMS should not move forward with a major change to the MA risk adjustment model under such an aggressive timeline. Instead, we urge CMS to extend the timeline for implementing changes to the MA risk adjustment model to allow sufficient time for both plans and providers to consider its impacts.

2. <u>Unclear Effect of Model</u>

We are concerned that CMS has not provided stakeholders with detailed information on the estimated effect of the changes to the HCC model. This information is vital to accurately predicting the costs of providing care. It is particularly concerning the proposed changes include

HCCs for those patient categories with significant clinical needs, including patients with diabetes or congestive heart failure.

A specific area of concern is how the proposed changes affects coefficient values for the diabetes group. In the proposed version 28 (v.28) of the HCC model, all coefficients are the same regardless of complication status, a shift from earlier models. Under earlier models, diabetes with complications (acute or chronic) had a higher coefficient than an uncomplicated diabetes, in recognition of the differences between two such patients. For example, v.24 HCC18 Diabetes with chronic complications coefficient was .302 for community, nondual aged. The proposed v.28 model utilizes the coefficient is 0.166, regardless of whether or not a patient with diabetes had chronic conditions. As proposed, the following HCCs carry the same weight in the risk score:

- HCC36 – Diabetes with Severe Acute Complications
- HCC37 – Diabetes with Chronic Complications
- HCC38 – Diabetes with Glycemic, Unspecified, or No Complications

Conversely, there are significant differences in the care needs for these patient populations.

CMS is proposing a similar approach with congestive heart failure, as the proposed model will have the same risk score for HCC224 [Acute on Chronic Heart Failure], HCC225 [Acute Heart Failure (Excludes Acute on Chronic)], and HCC226 (Heart Failure, Except End Stage and Acute). In support of the change, CMS cites its longstanding 10 Principles of Risk Adjustment, which the Agency used to establish the original CMS-HCC diagnostic classification system. For this proposal, CMS believes the change adheres to Principle 10, which reads:

> ***Principle 10 -*** *Discretionary diagnostic categories should be excluded from payment models. Diagnoses that are particularly subject to intentional or unintentional discretionary coding variation or inappropriate coding by health plans/providers, or that are not clinically or empirically credible as cost predictors, should not increase cost predictions. Excluding these diagnoses reduces the sensitivity of the model to coding variation and coding proliferation.*

AMGA does not believe that that Principle 10 supports the proposal. The codes selected for removal do not represent "discretionary" coding variation, but rather an increasing level of clinical severity. By proposing to collapse these HCCs into a single risk score, CMS is discounting the importance of risk adjustment in the MA program. AMGA members in any value-based care arrangement, MA or otherwise, understand how critical accurate risk adjustment is for any population health based model.

3. <u>Downstream Impacts</u>

The proposed removal of codes from the HCC model, many of which represent conditions prevalent among disadvantaged populations, is of concern for AMGA members. Additionally, this removal is in stark contrast with CMS' commitment to advance health equity throughout our public health system. It is difficult to predict with any certainty how practices would need to adapt to the expected decrease in reimbursement from MA. The inability of the HCC model to no longer recognize certain patient comorbidities and conditions, as proposed, may have

significant downstream implications for providers and patient access.

This proposal likely will reduce payments to plans, and ultimately providers who care for patient with chronic conditions. Unfortunately, given time constraints, AMGA is unable to provide data on the effects on how our members currently use the codes slated for removal. However, AMGA members do use these codes for preventive care, which is a critical aspect of any value-based or population health based model. Absent a detailed analysis of the effect of the proposed change, it is difficult to predict with any certainly how practices would need to adapt to the expected decrease in reimbursement from MA.

AMGA recommends that CMS not finalize the proposed changes to the HCC model but instead works with all stakeholders in 2023 so providers, plans and CMS can better understand the impact of this proposal.

We thank you for your consideration of our comments. Should you have questions, please 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