AMGA
Advancing High Performance Health

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March 1, 2024

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) 2025 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 2025 Advance Notice. Specifically, we are providing comments on the following:

- **Benchmark Rates and Risk Adjustment Model Phase-In**: CMS should reconsider the cut in the proposed benchmark rate and the continued phase-in of the new CMS-HCC model. With MA plans forecasting higher costs, AMGA recommends delaying the transition to the 2024 model to provide relief to providers grappling with financial pressures amid ongoing healthcare uncertainties.

- **Star Ratings and Universal Foundation:** AMGA fully supports CMS' use of the Universal Foundations set and believes implementing one core set of measures across all CMS value-based programs will significantly reduce the complexity of entering these programs.

- **Star Measurement Concepts and Social Needs**: AMGA appreciates the value of screening and better understanding beneficiary social needs and supports CMS' effort to enhance existing measures. However, addressing any identified needs ultimately is the responsibility of providers, a difficult prospect given resource constraints.

Our detailed comments are included below.

**Benchmark Rate and Risk Adjustment Model Changes**

CMS is proposing changes in the Advance Notice that would result in a 0.16% reduction in the 2025 benchmark rate compared to current policy. This reduction is driven largely by changes to the CMS-HCC risk adjustment model, which CMS projects to have a -2.45% impact on the benchmark rate. AMGA is concerned the benchmark rate reduction and coding changes will create uncertainty in the Medicare Advantage program. This uncertainty coincides with an unexpected rise in MA plan costs and a major cut to Medicare Fee-For Service (FFS) payment rates.

Medicare Advantage plans are forecasting higher than expected costs due to a variety of factors, such as a surge in elective procedures, which were deferred during the Covid-19 pandemic. Consequently, CVS Health expects Medicare Advantage medical costs will be $400 million greater this year than previously projected.[1] Other insurance companies—including UnitedHealthcare and Humana—have issued similar warnings their spending on Medicare Advantage members outpaced projections.[2] As a result, AMGA expects Medicare Advantage plans to pay providers less for providing services to MA beneficiaries. This compounds the financial pressure on providers also experiencing an overall payment reduction in Part B services, as Medicare cut the conversion factor for physician payments under Part B from $33.89 in 2023 to $32.74 for 2024 (a decrease of $1.15).

Cutting the benchmark rate for Medicare Advantage will only exacerbate financial pressure on providers who are experiencing payment reductions in FFS and who will almost certainly see reductions in MA irrespective of CMS proposals. Accordingly, AMGA believes CMS should delay its continued implementation of the 2024 CMS-HCC model.

In CY 2024, CMS introduced the CMS-HCC risk adjustment model, with plans to implement it fully by 2026. The model included updates such as restructuring condition categories, using ICD-10 codes, and incorporating more recent data. For the 2024 payment year, CMS calculated risk scores as a blend of the 2020 CMS-HCC model and the updated 2024 model. For 2025, CMS is proposing to continue the phase-in, with risk scores calculated as a blend of 33% from the 2020 model and 67% from the 2024 model.

When CMS first proposed these changes, AMGA recommended CMS not finalize them due to the short timeframe for implementation, the uncertain effects the changes to the model would have, and the anticipated downstream implications for providers and the patients they serve. AMGA was particularly concerned the proposals would reduce payments to plans, and ultimately to providers. Unfortunately, AMGA members are experiencing significant reductions from Medicare Advantage plans. Delaying the next step of the transition to the 2024 model would provide relief and allow time for plans to weather the unexpected rise in utilization and for congress to find a solution to FFS reimbursement. Medicare Advantage has become a source of stability for providers who have dealt with uncertainty in Part B reimbursement and frequent changes to other risk-based programs. Delaying this transition would allow the program to continue to anchor providers amid an uncertain period in healthcare.

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[1] "Aetna forecasts higher Medicare Advantage costs," Modern Healthcare, Feb. 7, 2024

[2] "Medicare Advantage provider, benefit cuts may follow rate reduction," Modern Healthcare, Feb. 6, 2024

AMGA members report the phase-in of the HCC changes already is effecting group practices and integrated systems of care that have a significant number of their patients enrolled in Medicare Advantage. For example, AMGA members report MA plans are eliminating benefits, which has a direct effect on patients. As provider organizations, AMGA members are facing the possibility of staffing reductions, eliminating programs, and reevaluating their strategic plans to account for the reductions in MA. The effect of these changes to MA will not be restricted to the plans or the insurance industry. Instead, the ramifications quickly will reach patients and providers.

**Universal Foundation Measure Set**

CMS is implementing a "Universal Foundation" of quality measures, which will create a core set of measures aligned across programs. AMGA is pleased CMS is working to incorporate the Universal Foundation measures into the Part C and Part D Ratings, pending future rulemaking. 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.[3]

In the Advance Notice, CMS noted several of the Part C Star Rating measures are part of the Universal Foundation. These include: Breast Cancer Screening, Colorectal Cancer Screening, Controlling Blood Pressure, Diabetes Care – Blood Sugar Controlled, Plan All-Cause Readmissions, and CAHPS Overall Rating measures. We highlight these measures were included in AMGA's measure set. It is important, however, as CMS moves forward with the Universal Foundations' measure set, these measures are integrated in a way that underscores the core intention of streamlining quality measurement and reducing duplicitous measures. AMGA's goal in developing the measure set was to reduce the number of measures reported while still ensuring critical quality information is captured. 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.

## Star Measurement Concepts and Social Needs

AMGA supports CMS' efforts to account for social needs in Star Rating system. However, Star Ratings measures are based on services submitted by clinicians and labs for payment. The social screening and Health Outcomes Survey would fall into the same category. As a result, addressing any needs will become the responsibility of providers and health systems. AMGA members increasingly are working to partner with community organizations to address these needs, but resources are limited and such work is very labor and time intensive. As noted above, providers are concerned changes to the MA will strain limited resources. CMS must ensure MA provides the resources need if providers are to take on these additional responsibilities.

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

[3] "AMGA Endorses Streamlined Value Measurement Set to Reduce Reporting Burden." AMGA, June 25, 2018.

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Sincerely,

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AMGA