AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

March 5, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for the Medicare Advantage (MA) CMS-HCC Risk Adjustment Model and Advance Notice of Methodological Changes for CY 2019 for MA Capitation Rates, Part C and Part D Payment Policies and 2019 Draft Call Letter

Administrator Verma:

We appreciate the opportunity to comment on the calendar year 2019 Medicare Advantage (MA) Rate Notice and Call Letter.

America's Physician Groups (APG, formerly CAPG) represents nearly 300 medical groups and independent practice associations across 44 states, Washington, DC and Puerto Rico. Our members are paid percent-of-premium capitation by health plans in Medicare Advantage (MA) and some are globally capitated for both professional and hospital services. This population-based payment avoids the fee-for-service model's deleterious incentives for volume. Instead, this model aligns incentives for physicians to keep individual beneficiaries healthy as they improve the health of entire populations.

Our members' value-based payment arrangements create incentives for: (1) a team-based approach that emphasizes primary care; (2) physician organizations to provide the right care at the right time in the most appropriate setting; and (3) a care team that addresses the patient's total care needs, including mental health, behavioral health, and home environment.

We know that MA provides better quality care for seniors. The December issue of *Health Services Research* included an analysis of MA contracts in three states: California, New York, and Florida.[1] The study looks at performance on 16 clinical quality measures and six patient experience measures for 9.9 million beneficiaries. The study found that MA outperformed FFS

[1] *Timbie, J.W., et al, Medicare Advantage and Fee-for-Service Performance on Clinical Quality and Patient Experience Measures: Comparisons from Three Large States, Health Services Research (2017) available at http://www.hsr.org/hsr/abstract.jsp?aid=52656627620 (accessed January 11, 2018).*

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on all 16 of the clinical quality measures and on five of six patient experience measures.[2] Notably, MA-HMO plans outperformed MA-PPO plans on 14 of 16 clinical quality measures.[3]

Furthermore, we know that the way in which physicians are paid downstream from the MA plan has an impact on the quality of care that patients receive. Our members have long demonstrated that value-based arrangements downstream, including capitation, offer higher quality than fee-for-service payments downstream. A recent study in the *American Journal of Managed Care* confirmed compared quality between two physician groups: one where an MA plan paid fee-for-service downstream to physicians and one where the MA plan paid capitation to the physician group (an advanced alternative payment model or APM). The advanced APM group's patients had a six percent better survival rate than the FFS group. Further, the Advanced APM group achieved 11 percent lower emergency department utilization and nearly 12 percent lower inpatient utilization as compared to the FFS group.[4]

Given the evidence of superior quality in MA, we know that growing the program and encouraging innovation by plans and providers in MA is the right policy direction. We are encouraged that many of the policies in the proposed rule can further incentivize the growth and development of MA. Our specific comments on those proposals are set out below.

Encounter Data as a Diagnosis Source

For plan year 2019, CMS is proposing to increase the weight of encounter data as a diagnosis source from 15 percent to 25 percent. We oppose the proposed continued phase in of encounter data as a diagnosis source.

We remain concerned about the accuracy of the encounter data system. Ensuring the completeness, accuracy, and timely submission of encounter data is essential to ensuring accurate payment and high-quality care in MA. Potential errors in the data may undermine our efforts by inappropriately reducing resources to care for patient populations.

Specifically, in recent reports, both the HHS Office of Inspector General and the Government Accountability Office raised concerns about the accuracy of encounter data.[5] Both reports outlined additional steps the agency should or could take to improve encounter data. In light of these well-documented concerns, dating back to 2014, we believe it is improper to continue to expand the use of encounter data at this time.

Finally, we note that CMS has also proposed implementation of a new risk adjustment model, required by 21st Century Cures legislation to take into account additional information. In its

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[2] *Id.*

[3] *Id.*

[4] *Mandal, et al., Value-Based Contracting Innovated Medicare Advantage Healthcare Delivery and Improved Survival, Am. J. Manag. Care 2017:23(2).*

[5] *Statement of James Cosgrove, Director, Health Care, Government Accountability Office, Testimony Before the Subcommittee on Oversight, Committee on Ways and Means, US House of Representatives (July 19, 2017); Suzanne Murrin, Deputy Inspector General for Evaluations and Inspections, Medicare Advantage Encounter Data Show Promise for Program Oversight, but Improvements are Needed (January 2018).*

proposed implementation of the new risk adjustment model, the agency proposes to blend the new model with prior models. We note that these multiple blends and approaches to payment in MA are incredibly complicated to model, in particular for downstream contractors of MA plans. We encourage you to take a more measured approach to implementing changes to MA payments.

Medicare Advantage Coding Pattern Adjustment

In the advance notice, CMS is proposing to apply the statutory minimum MA coding pattern adjustment of 5.9 percent. However, the agency notes that it is considering additional methodologies to inform its final decision regarding the coding intensity cut for 2019 and future years. We ask that CMS adhere to the statutorily required amount for 2019. Going forward, we ask that the agency undertake a serious effort to understand and potentially address coding differences between MA and traditional Medicare. This effort should be informed primarily by risk bearing provider groups in MA and traditional Medicare.

An increase in coding intensity is an expected consequence of population health payment and delivery models that empower primary care physicians to identify and manage chronic conditions. Capitated, coordinated care delivery involves a complex gathering and exchange of patient information. At multiple levels within each of our organizations, we are assessing individual patient and overall population health. The information gathered is reported both within our systems and to health plans – the information provides the foundation for accurate payment but also creates the foundation of a communication system about the resources needed to completely manage the health of each individual patient. It should, therefore, be no surprise that in capitated coordinated environments, the information is more complete than in an unmanaged, FFS environment. And this is the result that CMS should want as it enables physician organizations to stratify their populations, design care management programs specific to their patients, and to predict future disease burden.

We understand that there are differences in how organizations code and the purposes for which they use coding information. We believe that sweeping, across the board cuts to align coding patterns in MA to FFS inappropriately penalizes physician organizations and plans that are using proper coding to better manage population health. A well thought-out approach to coding intensity would identify the "gold standard" approach for proper coding as a component of population health management and incentivize the right behaviors. We would be pleased to work with the agency to identify those behaviors and design policy changes that achieve the result of encouraging risk-based coordinated care models and population health management.

Advanced Alternative Payment Models in Medicare Advantage

We are pleased to see the agency's announcement that it intends to begin collecting information about advanced alternative payment model contracting from MA plans in April 2018. In the 2018 Quality Payment Program Final Rule, CMS announced that there would be

two pathways for advanced APM determinations in MA – a clinician-led pathway and a plan-led pathway. In the advance notice and call letter, CMS announces that it will not begin collecting information from clinicians until 2019. We encourage CMS to align the data collection for both pathways to April 2018. Implementing APM policy in MA is a critical step in advancing the policy objective of creating more APMs and promoting the movement to risk-based contracting. As you know, incentives have been in place for risk contracting in traditional Medicare under the Medicare Access and CHIP Reauthorization Act (MACRA); we firmly believe it is time to afford equal credit to providers taking risk in MA.

We look forward to the agency's announcement of the MA APM demonstration project, originally announced in the Quality Payment Program Final Rule late last year. Many of our organizations are either currently taking or plan to take risk from MA plans in the future and are eagerly awaiting this announcement so they can plan accordingly. We know that creating greater opportunities and incentives for risk contracting in MA will advance the Medicare delivery system for all seniors.

Increased Flexibility for MA Beneficiaries

We appreciate the agency's proposals to expand the definition of health-related supplemental benefits and additional flexibility in the benefit uniformity requirements. These changes will allow plans and providers to offer high value coverage for beneficiaries.

Benchmark Cap

The Affordable Care Act (ACA) imposed a cap on MA payments at the pre-ACA level. However, application of this policy has had the adverse effect of limiting payments for certain high quality MA plans and physician organizations with four or more Stars.

Many of our members are engaged in percent of premium capitation arrangements with MA plans. This means that the physician organizations are paid a percent of what CMS pays the plan, including quality bonus payments. The benchmark cap has the effect of limiting the quality bonus payments to plans and therefore to physician groups as well, all to the detriment of the beneficiaries they treat.

Specifically, quality bonus payments are included in the plan's benchmark calculation. If an MA plan earns four or more stars, qualifying for a quality bonus payment, the bonus amount is factored into the plan's benchmark. If that bonus causes the benchmark to exceed the ACA-imposed cap, the plan does not receive the quality bonus payment. This has the effect of limiting these quality bonus payments to the highest performing physician groups.

The quality incentives that physicians earn by providing superior care to beneficiaries are often re-invested in patient care – in the form of additional benefits and the provision of many coordinated care services. The benchmark cap limits our resources that can be re-invested in patient care and therefore should be eliminated.

New Technical Expert Panel

In the proposed call letter, CMS announces that it will establish a Technical Expert Panel (TEP) in 2018, comprised of representatives across various stakeholder groups to obtain feedback on the Star Ratings system. We strongly support the creation of a TEP for changes to the Star Ratings. We hope that you will view us and our member companies as a resource as you put together the panel.

Support for Puerto Rico's Medicare Advantage Program

Puerto Rico's highly-popular Medicare Advantage program plays a critical role in serving vulnerable Medicare beneficiaries and maintaining the stability of the Island's fragile healthcare system.

We remain concerned that the fee-for-service data used to set payment rates in Puerto Rico is insufficient and does not accurately reflect the true cost of serving MA beneficiaries.

While CMS has made important adjustments in past years to attempt to address these data deficiencies, we believe a more comprehensive solution is needed, especially in the wake of the recent hurricanes.

Therefore, APG supports the use of a temporary proxy rate or the use of a national Average Geographic Adjustment (AGA) floor until a long term methodological fix can be developed.

If CMS is unwilling to support these more comprehensive solutions, we urge the continuation of the existing administrative adjustments and others suggested by our members in Puerto Rico to prevent the continuing erosion of Puerto Rico's Medicare Advantage program and overall healthcare system.

Conclusion: Protect and Strengthen MA for the Future

Risk-based physician organizations in MA are at the leading edge of delivery system reform. The combination of appropriate financial incentives and the program's flexibility to invest in care management and population health make MA a popular option for our patients. Today, over 19 million seniors are enrolled in MA, over one-third of overall Medicare enrollment. We believe that this number will continue to grow as long as policy decisions support a strong future for this important Medicare option. We look forward to a final rate announcement that creates a strong MA program for the future.

Sincerely,

DONALD H. CRANE
President & CEO
America's Physician Groups