AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

March 1, 2019

The Honorable Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Medicare Advantage (MA) Advance Notice and Call Letter for CY 2020

Dear Administrator Verma::

America's Physician Groups (APG) appreciates the opportunity to respond to the proposals in the Medicare Advantage (MA) Advance Notice and Call Letter for CY 2020. MA is instrumental to the transformation of our nation's health care system from volume to value. Our doctors support MA because of the tools it provides to better coordinate care and manage the health of entire populations.

APG is a professional association representing over 300 physician groups nation-wide. Our tagline, "Taking Responsibility for America's Health," truly represents our members' vision and efforts to improve the health of the patients and communities they serve by practicing accountable, coordinated care though value-based alternative payment models. Our members have decades of experience in value arrangements in MA, including capitation, and are pleased to serve as a resource to you and your staff as your work to strengthen and improve the program now and in the future.

We know that MA provides better quality care for seniors,[1] and our members' value-based payment arrangements in MA 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.

Summary of APG's Comments

- **Encounter Data:** APG recommends that CMS delay further implementation of the Encounter Data System (EDS) and that the blend remains at 25 percent until a more complete and accurate set of encounter data can be developed
- **Normalization factor:** APG opposes the CMS proposal to implement a normalization factor of 1.075 and 1.069 which will negatively impact rates by 3.08 percent
- **Patient Condition Count:** APG recommends that CMS further delay the implementation of the Patient Condition Count (PCC) until more research can be completed

[1] https://www.bettermedicarealliance.org/sites/default/files/2018-07/BMA_Avalere_MA_vs_FFS_Medicare_Report_0.pdf

- **Benchmark cap:** APG recommends that CMS continues to explore mechanisms to adjust the benchmark cap so that high performers in the quality programs are rewarded thereby allowing additional benefits to be re-invested back to the beneficiary
- **Puerto Rico:** APG supports the specific rate increase for Puerto Rico to account for lower adoption of Part B on the island, higher incidence of zero claim enrollees, and other adjustments. We strongly believe that since the hurricane impacted the entire geography and did not leave any easy access to care for a significant period, the final four months of 2017 in the calculation of per capita costs should be given special consideration as well as other measures that were impacted.
- **Supplemental benefits:** APG supports allowing MA plans to provide non-primarily health related benefits to chronically ill enrollees, as directed by Congress in the Bipartisan Budget Act of 2018, and do not support a CMS list of approved chronic diseases or limits on such benefits
- **New quality measures:** APG supports incorporating new quality measures that incent plans to work more closely with physician organizations, specifically in terms of delegating risk
- **Value in MA :** APG supports policies in MA which incent plans and providers to participate in risk bearing models. APG also supports allowing risk arrangements in MA to count towards the initial MACRA advanced APM threshold, not simply as an "other payer"

Medicare Advantage Payment Rate

Per CMS's 2020 Medicare Advantage and Part D Advance Notice Part II and Draft Call Letter Fact Sheet, the expected payment change from contract year (CY) 2019 to CY 2020 is about 4.9 percent, including the underlying coding trend and excluding the rebasing/re-pricing of the county level benchmarks.[2] The components that make up this 4.9 percent are shown in the table below:

	Impact on Payments Relative to 2019
Effective Growth Rate	4.59%
Rebasing/Re-pricing	TBD[1]
Change in Star Ratings	-0.14%
MA Coding Intensity Adjustment	0.00%
Risk Model Revision	0.28%
Encounter Data Transition	-0.06%
EGWP Payment Policy	0.00%
Normalization	-3.08%
Expected Average Change in Revenue	**1.6%**
Coding Trend	3.3%
Expected Average Change in Revenue with Coding trend[2]	**4.9%**

1 – Will be available with the publication of the 2020 Rate Announcement
2 – Excluding the impact of the rebasing/re-pricing of benchmarks

As stated above, the 4.9 percent excludes the impact of rebasing/re-pricing the county level benchmarks which will be released in the CY 2020 final rate announcement on April 1, 2019. CMS has been consistently rebasing the benchmark rates and intends to do so for payment year 2020. This process

[2] https://www.cms.gov/newsroom/fact-sheets/2020-medicare-advantage-and-part-d-advance-notice-part-ii-and-draft-call

updates the county rates to reflect the current estimates of county spending. Historically, the impact on payments of the rebasing has been relatively small on average, 0.3 percent[3] for CY 2018 and 0.5 percent[4] for CY 2019.

However, the impact will vary by county and it can be large, particularly if a county moves into a different payment quartile. The true impact will be unknown until the CY 2020 final rate announcement is published. APG is concerned that the final amount may be insufficient to keep up with pace of inflation and other factors outside their control like benchmark caps.

Below we have provided comments on certain factors that are contributing to the payment rate change from CY 2019 to CY 2020.

Medicare Advantage Normalization Factor

In the Advance Notice, CMS is proposing CY 2020 normalization factors of 1.075 and 1.069 for the 2017 CMS-Hierarchical Condition Category (HCC) and proposed PCC model. The CY 2020 normalization factor results in about a 3 percent decrease in CMS payment from CY 2019, as shown in the table above. The methodology used to develop the normalization factor is the same for CY 2019 and CY 2020, however, the CY 2020 trend is increasing at a faster rate. CMS stated that the increasing trend can be attributed to the following factors:

- Demographics
- Reported health status in the Original Medicare population
- Implementation of ICD-10

CMS expects that the ICD-10 implementation will stabilize and therefore will result in more constant risk scores year over year. However, demographics and reported health status will continue to increase and drive the normalization factor trend upward.

To understand the increasing normalization factor, it is important to quantify how much each factor, demographics, improved coding in Original Medicare, and the ICD-10 implementation, is contributing to the trend. Therefore, APG urges CMS to provide this detail so our members can understand how much each factor is contributing to the normalization trend and if these factors will continue to drive trends upward in future years.

We believe that the ICD-10 conversion is a big driver of the risk score trend increase. This increase is due to increased specificity in ICD-10 versus ICD-9 diagnoses along with some corrections to the CMS mapping of diagnosis codes to HCCs. This trend is included in the linear regression CMS uses to develop the normalization factor. However, the first two years of data, 2014 and 2015, use ICD-9 diagnoses codes rather than ICD-10. Given this, the coding trend slope looks steep when it may be a one-time step function. We request that CMS consider making a one-time adjustment to the 2014 and 2015 data to be consistent with data in 2016 through 2018 or remove 2014 and 2015 data from the trend calculation. We agree that once ICD-10 is part of the underlying data for all years the result will be a more stable trend. However, this is not yet the case.

[3] https://www.cms.gov/newsroom/fact-sheets/2018-medicare-advantage-and-part-d-rate-announcement-and-call-letter-and-request-information

[4] https://www.cms.gov/newsroom/fact-sheets/2019-medicare-advantage-and-part-d-rate-announcement-and-call-letter

Thereby, APG does not recommend that CMS move forward on the current proposed normalization factor of 1.075 and 1 .069 which will negatively impact rates by 3.08 percent.

Encounter Data System Transition

CMS is proposing to increase the weight of encounter data as a diagnosis source from 25 percent in CY 2019 to 50 percent in CY 2020. The increased weight on the EDS scores is a concern given that there continue to be differences for some beneficiaries in the risk scores calculated using EDS vs. the Risk Adjustment Processing System (RAPS).

Specifically, in a report from Milliman,[5] an analysis was conducted on 2017 payment year risk scores to evaluate the differences between RAPS and EDS risk scores for individual beneficiaries. The majority of beneficiaries had identical RAPS and EDS risk scores, however there were still about 11 percent of beneficiaries that had different risk scores. This difference was larger for beneficiaries enrolled in a special needs plan (SNP), about 21 percent, while those enrolled in general enrollment plans only resulted in 8 percent differences in RAPS and EDS risk scores.

In addition, we note that CMS has proposed implementation of a new risk adjustment model, the PCC model described in more detail below. The EDS risk scores would exclusively use the PCC model while the RAPS risk scores would use the existing 2017 CMS-HCC model.

Additionally, providers are currently experiencing a large amount of burden in submission (and edit resubmission) of encounter data. We recommend that CMS delay further implementation of the transition from RAPS to EDS. Based upon experiences from providers regarding the heavy workload of the current EDS process, it is **imperative** that the transition is slowed (or even rolled back) until revisions can be made and a more streamlined and accurate set of encounter data can be developed.

APG recommends that CMS delay further implementation of EDS and the blend remains at 25 % EDS/ 75% RAPS until a more streamlined and accurate set of encounter data can be developed.

Payment Condition Count Model

The 21st Century Cures Act requires CMS to account for the number of diseases or conditions a beneficiary may have, making an adjustment as the number increases, in the CMS-HCC Risk Adjustment model. Given this, CMS is proposing the PCC model which includes condition counts. The PCC model is expected to improve the risk adjustment by improving the accuracy of the predicted average costs of each risk score segment[6] and prediction for high need beneficiaries with multiple chronic conditions.

CMS is proposing to start the count of conditions where the variable was positive (or increasing monotonically) and statistically significant in each segment. Having a count floor helps to ensure stability between years and encourages complete coding (avoids scenarios where reporting a diagnosis decreases the risk score). In addition, CMS is proposing a count cap to avoid wide swings in contract-level risk scores and maintain meaningful cost prediction of the HCCs. The count floor and cap are advantageous to ensure that the condition count coefficient will provide a positive adjustment to beneficiary risk scores and meaningful cost predictor of health status.

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[5] http://us.milliman.com/uploadedFiles/insight/2018/Medicare-RAPS-to-EDS-2017.pdf

[6] *Segments are community non-dual aged, community non-dual disabled, community full benefit dual aged, communitu benefit dual disabled, community partial benefit dual aged, community partial benefit dual disabled, and institutional.*

In its white paper,[7] Avalere estimates that the PCC model will increase CMS payments, on average, but the impact will vary by beneficiary depending on the number of HCCs. The PCC model is expected to have a larger increase in risk scores for beneficiaries with six or more HCCs, and little to no impact for beneficiaries with less than six HCCs. Therefore, the PCC model is expected to result in more payments for beneficiaries with multiple chronic conditions (where beneficiaries are prevalent in SNPs). The impact will initially be dampened as the PCC model is being phased in over three years. It will be blended 50/50 with the existing 2017 CMS-HCC model for CY 2020.

APG recommends that CMS further delay the implementation of PCC until more research can be completed. Having a system in which four to five HCCs results in a slightly lower payment while six or more HCCs leads to slightly higher (per Alvalere study) appears arbitrary. The non-linearity impact suggests more work is needed on the model to avoid unintended consequences.

Benchmark Cap

MA plans receive a payment based on the county benchmark rate. Plans with high quality ratings (Stars) receive a bonus payment. However, the amount of the payment is caped at the pre-ACA level. For some high performing plans, plans with four stars or higher, this has had the unintended consequence of limiting their payment. Effectively, they do not receive the quality bonus. If the goal of the Stars program is to reward high quality plans and to allow them to reinvest in the beneficiaries and their care, this does not happen due to the payment cap.

This issue has been raised in prior years to CMS and the Agency shares the concerns of commenters, but the benchmark cap has remained unchanged. Consistent with the past, there is no proposal in the CY 2020 Advance Notice to make any adjustment to this methodology, however it continues to be a limiting factor and disincentive for high quality plans.

APG recommends that CMS continue to explore mechanisms to adjust the caps so that high performers in the quality programs are rewarded thereby allowing additional benefits to be re-invested back to the beneficiary.

Puerto Rico

Puerto Rico's highly-popular MA program plays a critical role in serving vulnerable Medicare beneficiaries and maintaining the stability of the Island's fragile healthcare system. Over the past three years, CMS has adjusted the fee-for-service (FFS) experience in Puerto Rico to better reflect the number of zero claims found in the population. This has resulted in a more accurate benchmarking for MA in Puerto Rico. APG supports this.

We are also supportive of CMS using only claims and enrollment metrics for beneficiaries with both Part A and Part B enrollment for years included in the historical data. This also allows for a more accurate picture of the FFS rate calculation.

In this new Rate Notice, CMS acknowledged the concerns raised by Puerto Rico Stakeholders in the wake of the hurricane regarding impact on per capita costs. However, CMS has indicated it will not do anything to adjust for this anomaly. We strongly believe that the uniqueness of situation, including the facts that it impacted the entire geography and did not leave any easy access to care for a period, requires some type of consideration for the final four months of 2017 for Puerto Rico. in addition to the

[7] https://avalere.com/wp-content/uploads/2018/10/Avalere-CMS-2019-HCC-Model-Impact-White-Paper.pdf

per capita cost's calculation, the hurricane impacted other calculations such as the Part D adherence measures that need to be adjusted. We appreciate that CMS has taken the time to research such concerns and as more information becomes available, APG looks forward to meeting with CMS to review.

APG urges CMS to continue to examine the use of the existing administrative and other adjustments suggested by our members in Puerto Rico to prevent erosion of Puerto Rico's MA program and overall healthcare system. 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 and concerns surrounding potential errors in per capita costs.

Supplemental Benefits

We appreciate the opportunity that Congress has afforded MA beneficiaries by lifting the uniformity standard and allowing expansion of supplemental benefits to the chronically ill. In this rate notice, CMS has defined chronically ill and the program parameters as well as requesting comments on future program parameters.

APG supports that health plans should have the flexibility to determine what is a chronic disease (meeting the current Section 1852 definition) rather than a list from a technical committee. This will allow plans to receive input from their providers regarding "non-primarily health related" items that would enhance the functional status of a chronically-ill enrollee. As plans and providers develop more experience in identifying novel items to contribute to enhanced health, we would not want an enrollee to be disadvantaged through a rigid bureaucratic system that has limited the definition of disease usage. Allowing the flexibility unleashes the creativity of the private sector and should be encouraged.

We do not support limits on these benefits nor the idea that financial need must be proven in order to allow access. This appears to be undue burden on both plans and providers in the implementation of these benefits and will limit the use of them in the long run.

APG supports allowing MA plans to provide non-primarily health related benefits to chronically ill enrollees, as directed by Congress in the Bipartisan Budget Act of 2018. We do not support placing arbitrary limits upon the benefits and or a determination of financial need.

New Quality Measures

CMS publishes the Part C and D Star Ratings each year to measure the quality of and reflect the experiences of beneficiaries in MA. In the Advanced Notice, CMS is soliciting feedback on possible future measure updates and new measure concepts including on physician/plan interactions in Medicare Parts C and D and CMS conducting a survey of physicians about their interactions with plans on behalf of beneficiaries.

APG supports this important concept of measuring physician/plan interaction. We think expanding the Star Rating program to encapsulate such a measure would better incent high-quality, coordinated care. We are cautious, however, about the encumbrance in compiling with a CMS survey. Such a survey must be conducted in the least burdensome manner.

APG also supports including a measure that considers the degree to which health plans delegate risk to their physician partners. APG has met with the CMS Deputy Administrator for Innovation and Quality, Mr. Adam Boehler, on the topic of better incenting the adoption of downside risk contracts. Unfortunately, APG members continue to face difficulties engaging health plans in this respect.

Numerous APG members have reported that some health plans are declining to enter into capitated contracts with them. These experienced groups have demonstrated success in capitated risk arrangements, and indicate they are ready, willing, and able to deliver risk-based care. These members have stated that the reluctance of plans to enter into risk contracts with providers is hindering the movement from volume to value – a transformation which ultimately leads to better care for beneficiaries at a lower overall cost.

We remain concerned that adequate incentives on the plan side do not exist and that plans remain reluctant to delegate risk downstream outside of California. Including a Star measure regarding delegation would be helpful to accelerate value in our health care system by rewarding plans for engaging in this type of value arrangement with phsyicans.

Value In MA

Under MACRA, certain qualifying models can become eligible for advanced APM status. The statute defines bonus-eligible advanced APMs to include Innovation Center demonstration projects, certain Medicare Shared Savings Program (MSSP) ACOs, and demonstrations required by federal law. Currently, to qualify for the five percent advanced APM bonus, APMs must have a certain threshold of their Part B Medicare FFS revenue or patients in an advanced APM.

Under current regulations and sub-regulatory guidance, only a handful of models qualify as advanced APMs with the majority of these models being tested through the Center for Medicare & Medicaid Innovation (CMMI) demonstrations. These existing CMMI models show promise but have thus far exhibited mixed results and modest success. Currently, no MA arrangements by themselves count as advanced APMs (only within the "other payer" category) and MA risk contracts do not count toward an organization's initial Medicare FFS risk threshold.

The limited number of models in Part B do not offer sufficiently attractive or numerous options for physician groups who want to qualify as advanced APMs. CMS clearly needs to swiftly adopt new advanced APMs to remedy this problem. We believe that the fastest and most equitable way would be is to allow a 5 percent bonus opportunity for participants in MA contracts that meet the Advanced APM criteria.

We firmly believe it is time to afford equal credit to providers taking risk in MA by giving the 5 percent bonus advanced APM bonus. This will allow greater opportunities and incentives for risk contracting in MA will advance the Medicare delivery system for all seniors.

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 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. It is essential that the program continue to grow and be stabilized during this period.

Conclusion

Thank you in advance for your consideration of our comments. We look forward to a final rate announcement that creates a strong MA program for the future. Further, we offer ourselves and our

members as a resource to you as you continue to work to strengthen and improve the MA program. Please do not hesitate to contact me or my Federal Affairs staff (Valinda Rutledge, VP of Federal Affairs vrutledge@apg.org; Margaret Peterson, Director of Federal Affairs mpeterson@apg.org) with any questions you may have.

Sincerely,

Donald H. Crane
President & CEO
America's Physician Groups