AMERICA'S PHYSICIAN GROUPS
Taking Responsibility for America's Health

March 4, 2022

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, DC 20201

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Administrator Brooks-LaSure:

America's Physician Groups (APG) appreciates the opportunity to comment on the Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. MA is instrumental to the transformation of our nation's health care system from volume to value. We know that MA provides better quality care for seniors 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.

About America's Physician Groups

APG is a national professional association representing over 300 physician groups that employ or contract with approximately 195,000 physicians that provide care for nearly 45 million patients. Our tagline, "Taking Responsibility for America's Health," represents our members' vision to move away from the antiquated fee-for-service (FFS) reimbursement system where clinicians are paid "per click" for each service rendered rather than on the outcomes of the care provided. Our preferred model of accountable, risk based, and coordinated care avoids incentives for the high utilization associated with FFS reimbursement

Summary of APG's Comments

CMS-HCC Risk Adjustment Model for CY2023

- Address the impact of social determinants of health on beneficiary health status by adding those additional factors to the demographics portion of CMS-HCC risk adjustment and incorporating the Zip Codes Model

MA ESRD Payment Rates

- ESRD patients into the MA program is only at its beginning stages, so any major changes made regarding ESRD must be fully vetted and carefully planned and implemented. CMS should continue to research multiple methods of calculating dialysis rates before it chooses one and begins implementation

Normalization Factors

- We disagree with this proposed change from the agency to use pre-pandemic years in this calculation and recommend that CMS continues using the previous five years to calculate normalization as it has done historically

Potential New Measure Concepts and Methodological Enhancements for Future Years

- We are supportive of any effort to include those patient populations that have historically suffered more from social risk factors, but caution the agency that steps toward accounting for health equity and social risk factors should be phased in slowly
- The development of a measure to assess plan screening for health-related social needs would encourage greater health plan activity within MA and reinforces some of the negatives of the quality measures program that focuses more on processes instead of results
- CMS should move the Star Ratings program toward emphasizing the strengths and advantages of value-based arrangements between providers and plans where outcomes, greater care coordination, and the improvement of care

Benchmark Cap

- CMS should Lift the cap to avoid disadvantaging high quality plans and ultimately providers

Measure Updates for 2023 Star Ratings

- While we generally agree with no longer use member-years of enrollment and instead aligning with PQA's measure specifications, we recommend that the dates of beneficiary stays, inpatient and SNF should be excluded from any methodology that CMS chooses to use.
- We disagree with the agency's classification that the changes to the Colorectal and Breast Cancer Screening measures would be non-substantive and ask that it first be displayed for at least one to two years
- We do not recommend creating an adult vaccination measure as it would result in substantial burden for healthcare organizations and providers

Background

Medicare Advantage Payment Rate

Per CMS's 2023 Medicare Advantage and Part D Advance Notice Fact Sheet, the expected payment change from contract year (CY) 2022 to CY 2023 is about 4.33%, excluding the rebasing/re-pricing of the county level benchmarks and coding trend.

CMS has been consistently rebasing the benchmark rates and intends to do so for payment year 2023. This process 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%2 for CY 2018, 0.5%3 for CY 2019, 0.02%4 for CY 2020, -0.4%5 for CY2021, and 0.16%6 for CY2022. 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 2023 final rate announcement is published.

In addition, the 4.33% excludes the impact of the coding trend which is typically provided by CMS but given the COVID-19 pandemic and how this is expected to vary significantly by plan, CMS has stated that they will not be providing the 2023 coding trend. Historically, the impact on payments of the coding trend has been relatively large and increasing on average, 2.5%2 for CY 2018, 3.1%3 for CY 2019, 3.3%4 for CY 2020, and 3.6%Error! Bookmark not defined. for CY2021.

Comments

CMS-HCC Risk Adjustment Model for CY2023

The agency is also asking for feedback on whether the CMS-HCC risk adjustment model can be improved by addressing the impacts of social determinants of health on beneficiary health status by incorporating additional factors that predict the relative costs of MA enrollees. And whether you have social determinant models to suggest.

APG and its members are supportive of addressing social determinants of health (SDOH) through predicting costs and are generally in favor of any policy change that allows risk adjustment to differentiate between people who are more expensive because of how social factors intertwine with the health status. We would also caution the agency to be mindful of any potential operational burden that could be created in incorporating predictive factors for relative costs through data collection or worries regarding a lack of guardrails to protect against potential gaming of any implemented system.

Our recommendation for how to address this concern and improve how the impact of social determinants are addressed is to add these additional factors to the demographics portion of CMS-HCC risk adjustment and to use the zip codes model. The zip codes model serves as a quality indicator of socioeconomic status and is easy to integrate into the geographic portion of the demographic and HCC models. Using this is a good way to address the need to improve assessment of SDOH impact while buttressing against potential burden that could come down the line.

MA ESRD Payment Rates

CMS seeking stakeholder comments on the potential impact of MA ESRD payment rates for rural and urban underserved populations. The agency considered calculating dialysis rates at the CBSA (Core-based Statistical Area) level instead of the state level but opted not to after it found that rural CBSA rates would decrease by 2.6% and increase for urban CBSAs by 0.5%.

Our view is that the recruitment of ESRD patients into the MA program is only at its beginning stages, so any major changes made regarding ESRD must be fully vetted and carefully planned and implemented. MA organizations are at the disadvantage where they are currently paid at FFS rates for dialysis centers while dialysis centers can negotiate much higher rates and do not have to accept FFS rates from MA organizations. There is also the issue of the recent push to conduct more home-based dialysis for patients which is more expensive than even treatment conduct in dialysis centers, despite some long-term benefits such as a reduction in hospital admissions and complications from treatment, but in the short-term it presents a real cost problem. **Our recommendation is that CMS continue to measure the multiple methods of calculating dialysis rates before it selects one and begins implementation.** Creating the right incentives within the payment structure to reach fair and appropriate ESRD payment rates will be an integral part of the agency's strategy moving forward.

Normalization Factors

CMS plans to use the methodology it typically uses for calculating the normalization factor, projecting the payment year risk score using five historical years of fee-for-service (FFS) risk

scores under the payment year model. CMS typically uses the most recent years of available FFS risk scores to calculate the trend but doesn't plan to update the years in the trend for 2023 due to concerns that the changing use of services in 2020 due to the pandemic resulted in an irregular 2021 risk score, which will significantly underestimate what the 2023 risk score is likely to be. The agency instead plans to use the 2016-2020 FFS risk scores that were used to calculate the slope for the 2022 normalization factors.

We disagree with this proposed change from the agency to use pre-pandemic years in this calculation. Healthcare organizations nationwide are still deeply engaged in treating people affected by coronavirus and dealing with the fallout of the pressure placed upon the healthcare system as a result. Dates of services have still depressed utilization over for providers over the past few years while patient populations have increased in sickness. The risk model likely continues to undercalculate the actuarial risks based on status. **We recommend that CMS continues using the previous five years to calculate normalization as it has done historically.**

Potential New Measure Concepts and Methodological Enhancements for Future Years

Stratified Reporting (Part C and D)/Health Equity Index (Part C and D)/Screening and Referral to Services for Social Needs (Part C)

CMS has asked stakeholders to provide feedback on key aspects of Part C and D Star Ratings measures, including plans to enhance current CMS efforts to report stratified Part C and D Star Ratings measures by social risk factors to help MA and Part D sponsors identify opportunities for improvement; the development of a Health Equity Index as an enhancement to the Part C and D Star Ratings program to summarize measure-level performance by social risk factors into a single score used in developing the overall or summary Star Rating for a contract; the development of a measure to assess whether plans are screening their enrollees for health-related social needs such as food insecurity, housing, and transportation.

We are supportive of any effort to include those patient populations that have historically suffered more from social risk factors. Improving the reward factor would be appropriate and work toward improving performance **but caution the agency that steps toward accounting for health equity and social risk factors should be phased in slowly.** Beginning this process with data collection that will allow for healthcare organizations to invest in the necessary infrastructure and processes for easily capturing appropriate data. Immediately implementing measures that hold providers accountable for outcomes before they are able to properly identify and account for these patient populations will hamper their ability to be successful in improving the care they are provided.

When it comes to the development of a measure to assess plan screening for health-related social needs, **we would caution the agency that doing so would encourage greater health plan activity within MA and reinforces some of the negatives of the quality measures program that focuses more on processes instead of results.** Providers should be incentivized and encouraged to treat conditions such as a1c instead of simply screening for it. The changing of care delivery and outcomes must be at the forefront of any implemented policies rather than information gathering.

Value-Based Care (Part C)

CMS also asked stakeholders about the development of a measure to capture the value-based care arrangements MA organizations have with providers based on health outcomes and quality of services provided to their patients, including how plans are aligning incentives with their providers so that they are rewarding better value and outcomes rather than the volume of services. CMS is interested in how to potentially structure a measure that focuses on how MA organizations contract with providers and what percentage of their providers have value-based contracts and what types of arrangements these contracts entail.

The promotion of value-based care is the hallmark of APG as an organization. We have been advocating a measure similar to what CMS is exploring with this RFI. **It is our recommendation that CMS should move the Star Ratings program toward emphasizing the strengths and advantages of value-based arrangements between provider and payor organization where outcomes, greater care coordination, and the improvement of care overall as opposed to the current outsized focus on screening and survey measures.**

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 4 stars or higher, this has 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 they share the concerns of commenters, but the benchmark cap has remained unchanged. Consistent with the past, there is no proposal in the CY 2023 Advance Notice to make any adjustment to this methodology as CMS believes that section 1853(n)(4) of the Act prohibits CMS from removing the quality bonus from the cap. However, it continues to be a limiting factor and disincentive for high quality plans. **APG**

believes that the cap should be lifted to avoid disadvantaging high quality plans and ultimately providers.

Measure Updates for 2023 Star Ratings

Medication Adherence Measures (Part D)

When applying the sociodemographic status risk adjustment for the medication adherence measures, CMS is considering whether to no longer use member-years of enrollment and instead aligning with PQA's measure specifications of continuous enrollment as defined by the treatment period and exclude beneficiaries with more than 1-day gap in enrollment during the treatment period.

While we generally agree with this proposed change and the agency's concerns on the level of complexity and accuracy when applying member-year enrollment in the SNF adjustments, we do recommend that the dates of beneficiary stays, inpatient and SNF should be excluded from any methodology that CMS chooses to use. The methodology that the agency chooses matters less than removing the dates of beneficiary stays, inpatient and SNF being brought into alignment.

Colorectal Cancer Screening (Part C)/Breast Cancer Screening (Part C)

CMS is proposing to removing the hybrid reporting method in measurement year 2022 or 2023 and transitioning to electronic clinical data systems (ECDS) reporting only beginning in measurement year 2023 or 2024 for multiple measures including Colorectal and Breast Cancers.

While it is important to move toward ECDS reporting, **we disagree with the agency's classification that this change would be non-substantive and ask that it first be displayed for at least one to two years.** The removal of hybrid specifications is a substantive enough change that providers should be given some time to adjust so they may be able to substantively account for the change.

Adult Immunization Status (Part C)

CMS is again soliciting feedback on the utility and feasibility of a vaccination measure for MA plans in the Star Ratings program.

In our view, the creation of a vaccination measure would result in substantial burden for healthcare organizations and providers as they seek to account for the measure, making its feasibility low. Creating such a measure would essentially hold providers responsible for

patient choices regarding vaccination at a time when many are refusing to become vaccinated despite what efforts are extended toward it.

Conclusion

Thank you for your attention to the above comments. Again, we reiterate our robust support for MA. It is important that CMS continues to work with stakeholders to encourage value in MA. Please feel free to contact Valinda Rutledge, Executive Vice President, Federal Affairs, (vrutledge@apg.org) if you have any questions or if America's Physician Groups can provide any assistance as you consider these issues. We look forward to a final rate notice that strengthens and improves the MA program for current and future beneficiaries.

Sincerely,

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