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Administrator
Centers for Medicare & Medicaid Services
CMS-4212-P
7500 Security Boulevard
Baltimore, MD 21244-8013

RE: Contract Year 2027 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit

Physicians for MA Beneficiaries, a coalition of risk-bearing value-based care provider organizations collectively treating thousands of Medicare beneficiaries in Florida and throughout the nation, submits the following comments on the *Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program* proposed rule.

Our coalition was formed so that CMS could hear the perspective of physicians on the front line of day-to-day care for MA beneficiaries. Our comments focus on preserving the role of risk-bearing providers in the MA program in order to maintain focus on clinical care, outcomes, and patient experience.

I. Background: The Risk to the Medicare Advantage Program from Unchecked Pressures on Physician Risk-Bearing Organizations

Physicians for MA Beneficiaries (PFMAB) is a coalition of physician organizations operating as risk-bearing organizations (RBOs) serving MA patients. We are at the forefront of value-based care, implementing advanced practice staffing and innovative programs to improve beneficiary health status, reduce costly hospitalizations, leading to more efficient use of federal Medicare funds. We have built the capacity to give our patients more face-to-face time with their physicians, as well as giving our physicians fewer patients to focus on daily, providing time to develop treatment plans for all chronic conditions, rather than just treating the acute condition.

Value-based care arrangements for delivering advanced primary care typically consist of providers like our coalition members taking on sole responsibility for entire health services spend on a percentage of risk adjusted premium. Increasingly, some MA plans are placing RBOs at risk for items and services that do not relate to clinical care or medicine, including cash-benefits, non-health-related services, and others. PFMAB was created to raise the alarm over the threat to the success of the MA program driven by aggressive and unreasonable plan marketing practices focused on cash cards that undermine MA access and outcomes.

The effect of these practices, combined with reductions attributable to the V28 risk adjustment model, have been significant reimbursement cuts to RBO physicians treating the MA population. These cuts directly cause reductions in advanced primary care services, closure of offices, fewer physicians or clinical staff to treat patients, longer wait times and less access for MA enrollees. Over time, these adverse effects will undermine the promise of the MA program and its advantages over FFS in terms of outcomes, access and patient satisfaction.

II. Request for Information on Future of Risk Adjustment (Sec. VIII.B)

CMS solicits comments on opportunities for improving the risk adjustment in MA.

a. CMS asks for input on "Ensuring accurate payments for sicker beneficiaries, while rewarding effective treatment and favorable patient outcomes."

Rewarding treatment and outcomes should be accomplished through a separate mechanism from ensuring accurate payments for beneficiary health status through risk adjustment. Outcomes and risk adjustment are two separate concepts that should not be conflated.

Risk adjustment is intended to reduce or eliminate "the incentives to enroll only the healthiest, and thus least expensive, beneficiaries while steering clear of the sickest and costliest."[1] It does so by recognizing the different clinical risk profiles of different patients that bring with them different costs for providers to manage and improve the patient clinical status and achieve genuine efficiencies over traditional Medicare in addressing the same health conditions. Rewarding outcomes, on the other hand, should be accomplished separately through quality bonus payments.

We do not see how risk adjustment can be used to incentivize outcomes, other than that less risk adjustment means less funding for providers to effectuate chronic condition management. Simplifications in the model, such as with V28, undermine the resources available to providers to treat and manage underlying chronic conditions.

[1] *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 873-74 (D.C. Cir. August 13, 2021, reissued Nov.1, 2021), cert. denied, 142 S. Ct. 2851 (U.S. June 21, 2022) (No. 21-1140).

b. *CMS asks for comments on "Reducing manipulability of the risk adjustment system as well as the day-to- day administrative burden for both plans and providers"*

In addressing "manipulation" of the risk adjustment system, it is necessary to challenge some mistaken assumptions offered by some stakeholders. First, the prevalence of condition does not mean that providers don't face costs in treating that condition. The imposition of V28 were most severe of providers with high chronic patient populations.

Second, the intensity of diagnostic coding in Original Medicare should in no way be used to measure appropriate diagnostic coding in Medicare Advantage. These are two very distinct programs that, by design, present completely different incentives for coding. We speak with authority as physicians who have practiced and treated patients under both Original Medicare and MA platforms. When treating Original Medicare patients, physicians are incentivized to capture diagnosis codes (1) necessary and related to the treatment being provided, and (2) necessary for the payment of claims. These two purposes are a coding universe that is less than a comprehensive assessment of all diagnoses the patient may have. Physicians are disincentivized from spending their limited time on any other diagnosis coding.

Alternatively, under a value-based platform like MA, risk-bearing entities (plans and/or providers) are responsible for the total cost of care of any and all conditions that may arise in the plan year. Because risk bearing entities are paid in advance on a capitated basis, they are incentivized to fully and accurately project the possible clinical risk of patients under their responsibility for the year. Under MA, providers are unable to submit additional claims to CMS through the year for previously undiagnosed conditions that may arise and require treatment through the year. That is why the incentives under the two programs are so different so as to make comparisons meaningless.

c. *CMS asks "Which diagnoses are most essential for CMS to include in its MA risk adjustment model?"*

It is essential that CMS include the diagnoses with previous weights that it removed in the V28 model: Depression; Diabetes; Vascular; Angina. These and other conditions should be included when they are prevalent chronic conditions that require active treatment and management in order to prevent costly hospitalization.

Of these, diabetes is most important. The prevalence of diabetes among our patient panels ranges from 30% to 60% and we find significant variability in the cost of care for diabetic patients with and without complications. Our experience is that diabetic with complications cost beneficiaries cost about 200% more than those who are diabetic without complications. We also suggest the following:

- Equal Weighting for Duals – Ensure that the adjustment factors for any diagnosis for dual-eligible enrollees shall not be less than the adjustment for the same diagnosis for enrollees who are not duals.

- Positive Scores and Weighting of Conditions that Drive Medicare Hospitalization Costs - Ensure the risk adjustment methodology includes positive adjustments and weights for top costly conditions. "Costly conditions" could be defined as either:
    - Top 10 chronic condition diagnoses among individuals over the age of 65 that, *if untreated, will lead to inpatient hospitalization*
    - Top 10 principal diagnoses at inpatient admission based on *Medicare volume*. Currently septicemia, heart failure, diabetes with complication, renal failure, psychotic disorders, pneumonia, COVID-19, cardiac dysrhythmia, COPD, respiratory failure
    - Top 10 principal diagnoses at inpatient admission based on *Medicare cost*. Likely top 10: septicemia; osteoarthritis; CHF; complication of device, implant of graft; acute myocardial infarction; pneumonia; coronary atherosclerosis; acute cerebrovascular disease; cardiac dysrhythmia, degenerative disk disease

d. Focusing on Diagnosis Codes from Providers

As CMS is interested in simplifying the risk adjustment diagnosis collection process, and wishes to level the code collection, we recommend that CMS limit risk adjustment by not permitting diagnosis code collection performed by plans separate from treating physicians. Submissible codes would only come from providers coding at the point of service who can accurately reflect beneficiary health status, without leaving a perception of "upcoding".

e. Other Risk Adjustment Reform Considerations

CMS also must keep in mind the following regarding any future changes to the MA risk adjustment model.

- When CMS reduces risk adjustment values, those cuts are 100% passed through to risk-bearing providers. Under value-based care arrangements, cuts are borne, not by MA plans, but by physicians treating beneficiaries.
- When CMS proposes changes to risk adjustment, stakeholders should have at least one year to review and comment and examine underlying assumptions used by CMS. New risk adjustment models should be phased in gradually over multiple years.
- Frequent wild swings in revenue discourage investments in infrastructure needed to make value-based care available to Americans.

III. Request for Information on the Future of Quality Bonus Payments in Medicare Advantage (Sec. VIII.C)

CMS asks for information from stakeholders to inform future policy development and potential refinement to the quality bonus payment (QBP) structure for MA plans. We offer the following broad insights and principles for CMS to keep in mind when considering QBP reforms.

We welcome and support CMS' interest in refocusing the MA program on clinical care, outcomes, and patient experience. However, under the current MA model, a disconnect often exists between the incentives of the QBP and the providers responsible for clinical care of patients. Positive clinical outcomes are the achievement physicians and providers, but QBPs go to the MA plan without an obligation to pass them through to RBOs.

Too often, MA plans undermine the promise of value-based care and the MA program in how they treat QBP in relations to RBOs. Regardless of an RBO's role in achieving positive star ratings, plans pass through to providers 100% of premium reduction due to lower QBPs, but when QBP increases are achieved, plans use the increase to fund non-clinical items that are essentially marketing expenses, like cash debit cards.

Reform of QBPs requires a formal means to delineate between plans and risk-bearing providers who is responsible for stares ratings and who ultimately will control corresponding QBPs and how they are utilized to improve health outcomes.

Regarding specific new QBP measures, to the degree MA plans are incentivized by enrollment over outcomes, the proportion of the plan service fund dedicated to RBOs, and provider expenses will be cut to fund cash benefits and other supplemental benefits that act as marketing tools. As provider compensation drops below the cost of care, physician practices close, as has been witnessed in Florida, threatening robust access to MA physicians for beneficiaries.

CMS could counter this trend by adding new QBP measures for primary care provider availability. For example, a standard could measure, "Percentage of the beneficiaries residing in large metro and metro counties who have access to at least one provider/facility of each specialty type within the published time and distance standards." CMS could add standards to require at least two or more primary care providers that are not owned by the payer. CMS could add standards for wait time to schedule primary care appointment.

IV. Additional Recommendations for Regulatory Reform or Testing Through Innovation Center Demonstration Projects

A fundamental barrier to expanding value-based care through MA and seeing more providers bear risk is the current ability of MA plans to put RBOs at risk for items and services outside of the control of the providers that are unconnected to clinical care. So long as plans can

overtime pass more losses to RBOs and dedicate more of the program fund away from clinical care and into marketing and administrative expenses, the clinical and cost benefits of value-based care will be frozen.

CMS should use its authority through the Centers for Innovation to run demonstration programs to test new ways of allocating MA risk between plans and provides. For instance, CMS could strength the role of RBOs in the MA program through the establishing a standard Division of Financial Risk (DOFR) agreement. When providers are truly at risk, meaning the providers control the medical spend, then the providers get to make the medical necessity decisions, not plans.

Further, CMMI could test a new policy that, as a part of professional actuary certification of bids, attestation include that bids do not assume that contracted RBOs will operate at a loss. This is intended to prevent the plan practice of plans advancing competitive products based on underpaying providers. Further CMS could require plans to share MMR data to RBOs that breaks down C & D spend from rebate. Otherwise, we don't know if we are being paid correctly. Finally, CMS could limit amount of rebate that can go to debit card benefits to instead incentivize funds to cost-sharing reduction and benefits related to health outcomes.

V. Revise the List of Non-Allowable Special Supplemental Benefits for the Chronically Ill (Sec. III.A)

CMS is proposing to refine its regulations regarding cannabis products by amending current regulatory language to state more precisely that cannabis products that are illegal under applicable State or Federal law are not allowable as supplemental benefits. We wish to use this as an opportunity to identify other supplemental benefit policy changes that CMS should make for items that lack expectation of improving or maintain the overall function of the chronically ill.

a. Potential of Excluding Cash Cards Connected to Clinical Care

CMS needs to do more to ensure supplemental benefits are expected to improve beneficiary health status, otherwise plans will continue abuse the MA program and use supplemental benefits solely as a marketing tool. The growth of supplemental cash benefits necessarily diminishes funds for providers at a time when the medical expense trend is increasing. Without addressing these troubling trends, there is a risk that MA will lose its advantage in terms of health outcomes for beneficiaries over FFS. CMS should analyze whether there is casual relationship between the increasing direction of rebate to cash benefits and the increase in medical expense and utilization. From our physician membership perspective, MA plan enrollment seems to reflect the size of the git card, not the quality of the benefit design.

In our experience, cash or flex cards or debit cards, even when marketed as "health incentives," bypass the clinical decision-making process. Beneficiaries may use these funds for non-medical or discretionary purchases. From the physician perspective, there is no clinical proof

around improved outcomes related to the gift cards, in fact many of our providers' data shows exactly the opposite. Funds applied to gift cads are not applied to care we can prescribe or deliver and there is no guarantee that the spending improves the patient's health.

The aggressive growth of debit cards as a marketing tool has had other specific adverse effects for beneficiaries served by RBO providers. When MA plans place RBOs at risk for debit card use and then increase the portion of the premium dedicated to debit cards, it materially cuts provider compensation. This is one of the leading causes of provider closures and bankruptcies in Florida, leaving fewer value-based providers of advanced primary care available to serve seniors.

b. Alternative Means for CMS to Rein in Abuses in Cash Benefits for Marketing

CMS could classify formally cash benefits (plan expenditures on cash cards, flex cards, and cash rebates) as a marketing expense that shall be considered non-claims costs (administrative) under plan MLR requirements. This could apply to all cash benefits or only to cash benefits that are not truly in practice limited to a specific non-primarily health-related benefits (produce; pest control; transportation for needs; indoor air quality; complementary therapies, etc.). Or CMS could impose a ceiling on the value of regular cash benefits to enrollees (cash/flex cards and/or premium rebates) at some percentage of the value of the plan bid. The ceiling could be applied to value cash benefits relative to total plan bid or to value cash benefits relative to all supplemental benefits.

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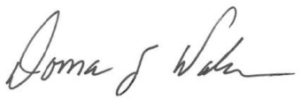
Thank you for your attention to these comments on the Advance Notice. We remain available to answer any technical questions that may arise out of these comments. Please feel free to reach us at Donna.Walker@inhealthmd.com or Phall@ebglaw.com.

Respectfully,



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