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February 26, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Hubert H. Humphrey Building, Room 314–G
200 Independence Avenue, SW
Washington, DC 20201

Attention: **CMS-2017-0163**
Submitted electronically to: http://www.regulations.gov

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 Call Letter

Dear Administrator Verma,

On behalf of **MemorialCare,** a nonprofit, fully-integrated health care delivery system located in Southern California that includes five hospitals with 11,000 employees and 2,550 medical staff physicians, we appreciate the opportunity to submit comments on the *Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 Call Letter* (2019 Advance Notice). Below we provide detailed comments with suggested modifications to the policies proposed by the Centers for Medicare and Medicaid Services (CMS).

Background:
The MemorialCare Medical Foundation (MCMF) includes our MemorialCare Medical Group (MCMG) and a multi-specialty Independent Practice Association (IPA), Greater Newport Physicians (GNP).

In Fiscal year 2017, both MCMG and GNP earned the rating of "Elite Status," the highest possible rating from America's Physician Groups (APG, formally known as CAPG). We have also been recognized by SCAN health plan as the two Top Performing Medical Groups in the State of California for three consecutive years. In 2017, the Integrated Healthcare Association (IHA) recognized GNP for its' excellent performance in the overall Medicare Advantage star rating of 4.5 stars, which is one of the highest scores set against national benchmarks established by the CMS across a set of 12 Part C (Medicare Advantage) and Part D (Prescription Drug Plan) performance measures. MemorialCare looks forward to continuing our efforts as health care moves forward to improve systems to reward value and outcomes.

Introduction:
MemorialCare is pleased to see the continuing support for MA programs as represented in the call letter. This is evidenced by the payment stability reflected in the 2019 Advance Notice, as well as the invitation for clinicians participating in Medicare Advantage payment arrangements to be included in Other Payer Advanced Alternative Payment Models (APMs). The MA program has been a successful model, demonstrating improvement in quality of care and population health, while maintaining affordability for beneficiaries through alignment of incentives. Continued support for the MA program will ensure that plans are able to continue to offer high quality options with attractive benefits at affordable premiums for seniors.

In light of this effort, we ask you to address the following areas in the final announcement:

Payment Model:
We appreciate CMS' transparency and solicitation for comments related to the payment model proposals in accordance with the 21st Century Cures Act. ***We recommend the best approach to be the Payment Condition Count Model, which will serve our beneficiaries and provide Medicare Advantage Organizations (MAO's) the opportunity to address mental health and substance abuse disorders that may be present in our patient populations.***

The Payment Condition Count Model does not show any potential for payment instability. However, we are concerned with a dual phase-in approach due to model alterations based on encounter data. Phase-ins cause difficulties in budget forecasts as well as administrative work in tracking accurate risk scores for patients. As the risk of payment instability due to implementation of the Payment Condition Count Model is small, a phase-in would be arbitrary and cause unnecessary administrative burden. In fact, a phase in of this model would cause instability through a higher risk of inaccurate budget forecasts and will create more harm than good. ***We request a more aggressive, or full, phase-in for the Payment Condition Count model, especially considering the proposed phase-in for encounter data.***

Dementia Omission:
Our provider organization remains concerned by the continued omission of dementia-related Hierarchical Condition Category (HCC) codes. Dementia conditions are included in Chapter 5 ICD-10-CM and, according to the notice, should have been assessed for inclusion in the proposed Payment Model. According to the Alzheimer's Association, in 2017 the annual payment for caring for individuals living with dementia reached $259 billion. Further, the association reports Medicare beneficiaries with dementia paid $10,315 out of pocket annually for health care not covered by other sources. MAO's that serve these beneficiaries may experience a negative disproportionate impact without appropriate risk adjustment. Our providers have reported a disproportionate increase in time and resources necessary to care for those impacted with dementia. ***We believe the dementia condition category***

needs to be included in the HCC codes to be consistent with the mandate of the 21st Century Cures Act.

Medicare Coding Pattern Adjustment:

CMS's proposal gives priority to adhere to the 2019 statutory minimum coding intensity adjustment factor policy. This does not make sense, since there is a system in place for coding practices administered through Risk Adjustment Data Validations (RADV's) to prevent widespread fraudulent coding practices. Further, through the RADV program MA diagnosis submission is subject to a much higher level of scrutiny than for fee-for-service (FFS) diagnosis coding and thus, is more likely to be more accurate. ***Even though there has been reported concerns about the coding intensity in the Medicare Advantage population, we strongly disagree with assertions of "upcoding" in MA.***

There is a high level of scrutiny for the current coding intensity adjustment factor (mandated by the Affordable Care Act over eight years ago), which has become artificially punitive and not reflective of current coding practices. Due to the RADV focus and the encouragement of plans to send in deletions retrospectively, coding intensity has likely depressed over the last few years for many plans and thus payment has been inaccurately reduced through this factor.

Further, appropriate identification of chronic conditions can be a powerful tool in population health. Across the board cuts to align coding patterns in MA to FFS disproportionately penalizes physician organizations, who are comprehensively and appropriately coding, and undermines efforts to utilize proper coding to better manage population health. ***We recommend a well-thought out approach to coding and recommend working with providers to create better policies.***

Encounter Data as a Diagnosis Source:

For Plan Year (PY) 2019 CMS proposes an increase in the weight of encounter data as a diagnosis source from 15% to 25%. Due to the operational challenges in implementation that have not been fully addressed, as documented by the HHS Office of Inspector General and the Government Accountability Office, we oppose the continued phase in of encounter data as a diagnosis source. Complete and accurate submission of encounter data is critical to ensuring accurate payment and high-quality care in MA. Phasing in payment calculations with a system that has known errors will inappropriately reduce necessary resources to care for our population. ***We encourage CMS to return to 0% Encounter Data System (EDS) as a source until the flaws have been addressed.***

Quality Proposal – Telehealth Services:

Utilizing innovative technology that will enable health systems to expand patient access points, through telehealth services, will also alleviate stress on on-site clinic based primary care resources. This proposal recognizes telehealth and remote access technologies as a method of data collection for Healthcare Effectiveness Data and Information Set (HEDIS), which will be a welcome enhancement for

our beneficiaries. ***We commend CMS for requesting the feasibility of and strategies to address telehealth services in the communities in which we provide health services.***

One of the barriers to telehealth expansion is policies that limit parity of telehealth providers compared to clinic-based providers. ***We recommend any telehealth inclusion for quality metrics should allow for two-way conferencing, to be included as a place of service for submission of Medicare encounter data***.

Two of the proposed measures cited in MA rate letter are for possible telehealth utilization for "High Blood Pressure Control" and "Comprehensive Diabetes Care." In our experience, using patient-provided home blood pressure (or blood sugar monitoring in the case of Comprehensive Diabetes Care) as the source of data is becoming normal, and yet requires substantial physician time to review collected data. The potential reduction in patient inconvenience in going to an office and the obviation of cost for paying for a full E/M visit goes to the patient and payer respectively, while costing the physician significant time that is uncompensated. ***We recommend that standards of care should be connected with some form of payment recognition despite the lack of a face-to-face visit between physician and patient.***

Quality Proposal – New Measures:

We appreciate greater transparency on 2020 measures, like those designed to address behavioral health and substance use. However, many of the proposed measures addressing these issues focus on the outcomes of these areas. We believe this is premature. Identification of the patient population, and understanding the issues surrounding this group will inform appropriate strategies to address the unique needs of these beneficiaries whom have previously been under-identified. Pre-mature focus on outcome measures may create strategies to align with the outcome measures for these patients rather than comprehensive reviews of these populations which will then develop best practice strategies. ***We encourage CMS to conduct a comprehensive identification and screening tool for behavioral health population to understand the needs of this patient population, before establishing outcome measures.***

Measures with multiple indicators are administratively burdensome, which is a critical issue for our providers and staff. The current medication reconciliation post-discharge measure captures the required elements intended for this measure, making the additional indicators redundant with no additional value for our beneficiaries. ***We do not support the "Transitions of Care" proposed measure with four indicators.***

There is significant variability in patients with two or more high-risk conditions. Including multiple assessments for these patients will hinder a clinician's ability to individualize the appropriate assessment across this population. It is the wrong approach for appropriate patient care. ***We do not***

support the "Assessment of Care for People with Multiple High-Risk Chronic Conditions" proposed measure.

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, 19 million seniors are enrolled in MA, and California has 40% Medicare Advantage penetration**.** We believe that this number will continue to grow as long as policy decisions support a strong future for this important Medicare option.

Based on this Advance Notice, MemorialCare looks forward to a final rate announcement that creates a strong MA program for the future. If we can be of assistance to CMS, please feel free to contact Kristen Pugh, Vice President for Advocacy and Government Relations, at KPugh@memorialcare.org.

Thank you for the opportunity to provide comments.

Sincerely,

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