March 15, 2024

VIA EMAIL

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RE: SUPPLEMENT TO PUBLIC COMMENT LETTER on "*CMS-2024-0006; Advance Notice of Methodological Changes for CY 2025 for MA Capitation Rates and Part C and Part D Payment Policies*"

The following information is submitted as a supplement to provide new data that expands upon points made in the March 1, 2024 comment letter from the trade group, Physicians for MA Beneficiaries. We have new data on how the continued implementation of the new risk adjustment model is negatively impacting beneficiaries under our care. Our timely submitted comment letter, attached, noted that this supplemental information would be forthcoming.[1]

Recall, *Physicians for MA Beneficiaries*, is a coalition of value-based physician organizations delivering "advanced primary care" to more than 200,000 Medicare beneficiaries at more than 800 locations. Our member physician practice models are consistent with CMS' definition of "advanced primary care" which CMS says consists of "improving primary care financing through increased, stable revenue that moves practices away from fee-for-service payments that pay for the volume of services delivered and toward support for team-based care, coordination with specialty providers, and community-based supports."

I. Profile of Impacted Patients

MA up to now has offered our physicians the ability to be at the front line of realizing CMS' vision of a "health system that achieves equitable outcomes through high quality, affordable, person-centered care." We specialize in treating low- to middle-income beneficiaries with high rates of chronic conditions. These are the very patients whose care is being

[1] See pages 7 and 8 of our March 1, 2024 comment letter, attached.

disproportionately and increasingly impacted by the ongoing implementation of the new V28 risk adjustment model.

- 25% to 40% of our patient panels are dual eligible for Medicaid and Medicare.
- The prevalence of diabetes among our patient panels ranges from 30% to 60%.
- Our physicians manage congestive heart failure in at least 20% of our patients.
- Our physicians manage angina, which is a symptom of significant heart disease, in at least 10% of our patients.

II. Observed Impact of V28 on Premiums and Benefits

CMS stated that it "anticipated stable premiums and benefits for individuals in 2025" under its proposals.[2] Instead, CMS should anticipate adverse changes in premiums and benefits for many beneficiaries in 2025 given the adverse changes observed by our provider members so far in 2024:

- Approximately one-third of our responding members report that their MA patients are already faced with increased cost-sharing in 2024.

- In addition to our member data, analysis by other stakeholders show that:

    - Deductibles have increased by 12% on average[3]
    - Some states are seeing average premium increases of up to 50%[4]
    - Supplemental benefits reductions. Among the 20 most popular categories of supplemental benefits, 9 categories are being offered in fewer plans and 13 will be available to fewer beneficiaries[5]
    - The most negative impact on risk scores in 2024 is for dual eligible beneficiaries and the 2025 impact is expected to be worse[6]

[2] CMS, 2025 Medicare Advantage and Part D Advance Notice Fact Sheet (Jan. 31, 2024); https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-advance-notice-fact-sheet.
[3] Analysis of CMS Landscape Files for CY 2024, Elevance Health Comment Letter on CY 2025 Advance Notice, pg. 24 (Mar. 1, 2024).
[4] Id.
[5] Id.
[6] Milliman, Impact of Medicare Advantage Part C Risk Score Model Change on 2024 Risk Scores (Feb. 2024); https://snpalliance.org/wp-content/uploads/2024/02/SNP-Alliance-2024-CMS-HCC-Model-Change-Survey-20240227.pdf

III. Observed Impact of V28 on Access to Preventive and Other Necessary Care

CMS stated that the continued implementation of V28 "is not expected to reduce access to preventive and other necessary care."[7]On the contrary, even with the phased-in implementation of the V28 model, a significant has already been observed ad should be publicly acknowledged and considered by CMS as reason to halt the continued phase-in of the V28 model.

- Approximately one-third of our responding members report that they've already dropped patient support services of non-emergency medical, which significantly curtails access for some of the most at-risk beneficiaries unable to find a way to get to crucial appointments.

- Half of our responding members report that average patient panel sizes have increased in 2024. This increased panel size is occurring partly due to insufficient funding to attract new physicians to fill vacancies, partly due to physicians exiting the value-based care space because of inadequate compensation, and partly due to increased burnout amongst the remaining providers being asked to care for larger panels with less support. This means that there are fewer physicians to see beneficiaries. The remaining physicians are burdened by higher workload with fewer support services, and the beneficiaries face longer wait times and shorter appointment times. All our responding members report that average patient panel sizes will increase further in 2025.

- All our responding members report that they have been forced to cancel plans to open or expand clinics in 2024 to meet the demand of a growing beneficiary population. One third of responding members report that they have been forced to commence some clinic closures in 2024 and anticipate ongoing further consolidation of clinic practices in 2025. This most significantly impacts at-risk populations in smaller communities, sometimes doubling or tripling the miles needed to travel to find providers or clinics able to care for their medical needs Patients seeking to transition to "advanced primary care" practices from traditional primary care are consistently finding long wait times and reduced capacity for care.

- All our responding members report that they will have to terminate clinical staff positions in 2025 if the new risk adjustment model continues. One member anticipates the need to eliminate 50% of clinical staff positions in 2026 under current trends. Dropping clinical staff necessarily has an impact on our members' ability to offer patient support services and person-centered care and increases the administrative and non-clinical workload on physicians, further exacerbating physician burnout and turnover.

- All our members report that the payment reductions continuing under current trends will necessitate eliminating physician positions in either 2025 or 2026.

[7] CMS, 2025 Medicare Advantage and Part D Advance Notice Fact Sheet (Jan. 31, 2024).

This summary and data provide growing evidence to CMS of the reality that reductions in MA plan rates have been and continue to be largely passed through to at-risk value-based providers treating MA beneficiaries through advanced primary care models. These cuts thus directly impact beneficiaries and the physicians most invested in caring for them. Such reductions should not and cannot be simply perceived as cuts to MA plans but rather as cuts to services for MA beneficiaries and the provider groups who treat them. Ongoing and further implementation of V28 is set to have devastating consequences on our nation's vulnerable seniors and shrink or eliminate many of the very groups of physicians who have so passionately invested in advanced primary care models.

Further implementation of V28 should be put on hold and CMS should report to Congress on the MA populations most impacted by V28 and the extent of benefit and access reductions in 2024. Beneficiary impact will otherwise be much worse in 2025.

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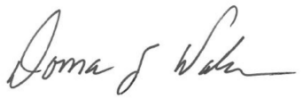
Thank you for your attention to these comments on the Advance Notice.

We request a meeting with you to further discuss the data we are producing on beneficiary impact and to answer any technical questions you may have on how advanced primary care practices are impacted by reductions in MA rates. Feel free to reach us at Donna.Walker@inhealthmd.com or Phall@ebglaw.com.

Respectfully,



Donna Walker
President

cc: Chiquita Brooks-LaSure, Administrator
Jonathan Blum, Principal Deputy Administrator & Chief Operating Officer
Cheri Rice, Deputy Director, Center for Medicare

March 1, 2024

VIA REGULATIONS.GOV

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RE: CMS-2024-0006; Advance Notice of Methodological Changes for CY 2025 for MA Capitation Rates and Part C and Part D Payment Policies

Physicians for MA Beneficiaries, a coalition of 22 value-based care provider organizations collectively treating over 200,000 Medicare beneficiaries at more than 800 locations,[1] submits the following comments on the *Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies*. 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. We want CMS and all stakeholders to understand how the Advance Notice, and in particular the new risk adjustment model, impact Medicare beneficiaries and our ability to deliver coordinated and preventive care.

I. SUMMARY OF COMMENTS

- Policymakers must acknowledge the reality that reductions in MA plan rates are largely passed through to at-risk value-based providers treating MA beneficiaries.
- Cuts therefore directly impact provider compensation and the level of patient centered preventive services available to treat and manage chronic conditions in vulnerable populations. Cuts should be understood as, not cuts to MA plans, but rather cuts to services for MA beneficiaries.
- Further implementation of V28 should be put on hold and CMS should report to Congress on the MA populations most impacted by V28 and the extent of benefit and access reductions in 2024. Beneficiary impact will otherwise be much worse in 2025.

[1] The majority of our present coalition members' locations are in Florida but our members treat beneficiaries in multiple states. Shortly, we will report new members joining with more locations in other states.

- Rate cuts in 2025 combined with double-digit increases in medical expense trends does not leave providers enough premium to maintain quality care for their patients.
- Our risk-bearing coalition members project a 15%-25% reduction in premium revenue to care for patients under the proposed policies for 2025. This will manifest as access restriction and reduced services.

II. BACKGROUND ON THE ROLE OF VALUE-BASED CARE PHYSICIANS IN TREATING MA BENEFICIARIES

a. Value-Based Providers are Already Delivering to MA Beneficiaries the Advanced Primary Care that CMS Wishes to Expand into Medicare Fee-for-Service (FFS)

In 2021, CMS set a goal of having "100% of Traditional Medicare beneficiaries in accountable care relationships by 2030."[2] CMS states that a mechanism to achieve this goal is through "advanced primary care", which CMS says consists of "improving primary care financing through increased, stable revenue that moves practices away from fee-for-service payments that pay for the volume of services delivered and toward support for team-based care, coordination with specialty providers, and community-based supports."[3] The CMS Innovation Center's Vision is a "health system that achieves equitable outcomes through high quality, affordable, person-centered care."[4]

MA evolves and adapts to manage specific health needs of beneficiaries. The providers who comprise our coalition are already making this value-based care vision a reality for our Medicare patients today in a way that FFS does not:

- Frequent check-in visits for patients identified as high acuity
- Advanced care clinic with additional clinical services to specifically serve patients who would otherwise go to the ED
- Post discharge timely follow-up and transition of care coordination with hospitalist teams
- Kidney care program serving patients in their home
- Case conferences for complex patients
- Protocol orders and/or acute rescue kits for patients with history of exacerbations/acute events
- Transportation to provider visits
- Home visit nurse practitioners and home health services
- Virtual Care clinic

[2] CMS, *The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care*, (Nov. 7, 2022); https://www.cms.gov/blog/cms-innovation-centers-strategy-support-person-centered-value-based-specialty-care

[3] Id.

[4] CMS, *Person-Centered Innovation – An Update on the Implementation of the CMS Innovation Center's Strategy,* pg. 3 (Nov. 2022); https://www.cms.gov/priorities/innovation/data-and-reports/2022/cmmi-strategy-refresh-imp-report.

- 24-hour access to providers through same-day access at walk-in clinics and 24/7 nurse line
- Dedicated in house and partnered pharmacists to support medication adherence, medication reconciliation, and appropriate therapeutic treatments
- Onsite spirometry to assess pulmonary function
- On site specialty care and other care, such as labs, imaging, x-ray, vascular ultrasounds, fundoscopy for diabetic retinal exams, echoes for early detection of heart failure
- ER Follow-up coordinators
- Preferred provider network of specialists who have proven patient health outcomes and cost efficiency
- Physician-led patient education sessions weekly or monthly
- Onsite wellness centers for social, mental and physical well-being, which may include exercise equipment, hair salons, educational seminars, exercise classes
- Ambulatory Care management
- Transitional care management
- Employed hospitalist model

We have built the capacity to give our patients longer appointments of 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. "Medicare Advantage enrollees were more likely than beneficiaries in traditional Medicare to receive preventive care services, such as annual wellness visits and routine checkups, screenings, and flu or pneumococcal vaccines, based on several studies, with similar findings for people of color and beneficiaries under age 65."[5] This is because the efficiency of coordinating care through primary care visits reduces the demand for specialty care services.

MA has substantially lower utilization and expenditures than FFS, even after rigorously adjusting for member enrollment differences across the two programs, including baseline demographic, clinical, and social risk factors. MA enrollees have more than 50% fewer inpatient stays and 22% fewer emergency doctor (ED) visits.[6]

These improvements in outcomes are driven by purposeful investment in programs to allow 24-hour access through nurse triage, same day walk in access, home based care delivered by clinicians, nurses, paramedics, etc. There are protocols designed for rapid treatments for acute problems which help reduce the risk of admission for ambulatory care sensitive conditions. Care

[5] Kaiser Family Foundation, *Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature* (Sept. 16, 2022); https://www.kff.org/medicare/report/beneficiary-experience-affordability-utilization-and-quality-in-medicare-advantage-and-traditional-medicare-a-review-of-the-literature/#:~:text=Preventive%20services%3A%20Medicare%20Advantage%20enrollees,for%20people%20of%20color%20and.

[6] Harvard-Inovalon Medicare Study: *Utilization and Efficiency Under Medicare Advantage vs. Medicare Fee-for-Service*, pg. 8; https://www.inovalon.com/wp-content/uploads/2023/11/PAY-23-1601-Insights-Harvard-Campaign-Whitepaper_FINAL.pdf.

coordination from inpatient to outpatient is a crucial component of readmission control. Clinical pharmacists and wellness visits help assure medication adherence in the ambulatory setting. There are programmatic investments for disease management, case management and accentuated focus on patients who utilize a lot of services. All these investments seem to pay off with reduced need for hospitalization despite patients having multiple chronic illnesses.

Through these numerous personalized touchpoints, we establish true relationships with our patients to better help them lead healthier, happier lives. We observe this resulting in lower rates of ER visits and hospital admissions which translates to lower costs to the healthcare system. MA also frequently outperforms FFS on achieving satisfactory quality measure scores.[7]

These results are possible because we have been willing to take on the burden of patient engagement, team-based care path planning and coordination to get better outcomes and reduce inappropriate or unnecessary utilization. MA drives more lasting investment in team-based, patient-centered care platforms than those in CMMI demonstrations. MA value-based providers have opened and are opening up offices and clinics dedicated to seniors, often in underserved areas. Whereas many CMMI models are an accounting exercise as opposed to a change in care paths available.

Wealthier seniors can afford access to these services by paying concierge fees or purchasing a Medigap policy to assure predictable expenses. That is why MA remains the best option to meet the health care needs of low- and middle-income beneficiaries. The 20% coinsurance of FFS is unaffordable for many seniors. MA's maximum out-of-pocket limit reduces the fear for beneficiaries of unlimited potential out-of-pocket costs which might otherwise affect those in FFS. Extra assistance with paying prescription drug cost-sharing and Part B premiums are additional reasons why MA has become a more attractive choice for lower income beneficiaries.[8]

Part B premiums have been increasing rapidly and have an outsized increased cost for wealthier seniors. Those lower- and middle-income seniors who choose MA are able to recoup the Part B premium increase through lower out-of-pocket expenses for coinsurance, co-pays and supplemental benefits like dental, hearing and optical. On balance, MA beneficiaries' out-of-

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[7] Timbie, Bogart, Dahlberg, et. al., *Medicare Advantage and Fee-for-Service Performance on Clinical Quality and Patient Experience Measures: Comparisons from Three Large States*, Health Serv. Res., 52(6):2038-2060 (Dec. 2017); https://pubmed.ncbi.nlm.nih.gov/29130269/#:~:text=Principal%20findings%3A%20Overall%2C%20MA%20outperformed,reported%20better%20access%20to%20care.

[8] *See* The Commonwealth Fund, *As It Grows, Medicare Advantage Is Enrolling More Low-Income and Medically Complex Beneficiaries: Recent Trends in Beneficiary Clinical Characteristics, Health Care Utilization, and Spending*, Issue Brief (May 13, 2020). ("Between 2012 and 2015, the MA population grew younger and included greater proportions of racial and ethnic minorities. There were also more low-income beneficiaries, more living in poor neighborhoods, and more living in neighborhoods where few residents have college degrees. While chronic conditions had not become more prevalent by 2015, a greater proportion of beneficiaries had complex medical needs.") https://www.commonwealthfund.org/publications/issue-briefs/2020/may/medicare-advantage-enrolling-low-income-medically-complex.

pocket costs, which is often what they prioritize, is lower despite the slightly higher Part B premiums that are drawn from Social Security payments.

MA also provides a means for physicians to be fairly compensated for aligning their work with the outcomes of their patients. It allows physicians to continue to treat seniors while escaping plummeting FFS payment rates, instead of dropping Medicare patients altogether.

b. Federal Reductions in MA Plan Payment Rates are Generally 100% Passed Through to Beneficiaries and Providers

Federal policy makers need to understand that reductions in federal payments to MA plans are generally passed through to beneficiaries and providers. 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 precentage of risk adjusted premium. Therefore, our coalition members feel as if reductions in MA payments through the new HCC risk adjustment model are penalizing providers who have done the most to deliver the reality of value-based care to Medicare beneficiaries.

Additional reductions to MA will undermine the value-based care goals CMS has already achieved through MA. Stable, predictable federal funding is a prerequisite to the private investments needed to make value-based care available to beneficiaries. The alternative to risk-assuming, entrepreneurial providers supported by private investment is standards FFS practices of 1 or 2 physicians that lack funding for NP/PA staff support and tech infrastructure to enable patient engagement and patient follow-up, as well as the additional services listed above to improve outcomes and prevent ED Visits and Hospital Admissions.

III. HALT FURTHER IMPLEMENTATION OF THE V28 RISK ADJUSTMENT MODEL PENDING ANALYSIS OF IMPACT ON MOST VULNERABLE BENEFICIARIES (SEC. G)

CMS introduced a new Part C risk adjustment model in 2024. The new model updated the data years used to calculate Part C risk factors, transitioned to the use of ICD-10 diagnosis codes for identifying hierarchical condition categories (HCCs), and made numerous changes to the diagnoses and HCCs included in the payment model. In the final Rate Notice, CMS decided to phase in the model over a period of 3 years rather than implement it entirely in 2024 as originally proposed. In 2024 CMS blended Part C risk scores using 33% of the risk score based on the new model and 67% of the risk score as calculated under the old model. For 2025, CMS proposes to continue phasing in the new model with a blend risk score based on 67% of the new model and 33% of the old model.

Continued phase-in of the risk adjustment model will further degrade our ability to deliver advanced primary care to Medicare beneficiaries in 2025. Beneficiaries will have less access to a lower level of advanced primary care.

a. Beneficiary Cost-Sharing Increased and Benefits Offered Decreased in 2024 Due to the V28 Risk Adjustment Model

CMS states that it "anticipated stable premiums and benefits for individuals in 2025" under its proposals.[9] In fact, CMS should anticipate the opposite given what has been measured and recorded for 2024.

Equally troubling evidence exists at the national level to contradict the claim. Analysis by Milliman shows that the average value-add for general enrollment MA plans stopped growing in 2024 due to "MAOs . . . reducing benefit levels or are keeping them level versus investing in additional offerings or increasing the richness of offerings."[10] This effectively means the end of innovation in benefit design to address beneficiary needs. Milliman analysis also shows that, far from being stable, the national average cost-sharing (MOOP) for general enrollment MA plans *increased* in 2024. BRG estimates "the value of supplemental benefits or reductions to premiums and cost sharing could fall by $33 pmpm or more per beneficiary per month, on average."[11] The reduction of value is projected at $24 for MA beneficiaries in Florida, and a reduction of value of $43 for dual-eligible beneficiaries in Florida.[12] This would result in our beneficiary patients facing an additional increase in the health care costs and/or reduction in benefits in 2025.

More generally, analysis of the 2024 MA landscape files shows the number of MA plans available in the market declined by 10%, with some states seeing declines of more than 20%. The number of zero premium plans declined by 13% overall. In addition, average plan deductibles increased by 12%. If such premium and benefit instability was observed in the first year of the phase-in of the HCC risk adjustment model, we are not aware of any argument as to why the impact in 2025 would not be the same or worse.

We will shortly supplement this comment letter with additional data on our coalition members' observed impact of the new risk adjustment model on beneficiary cost-sharing and benefits in 2024.

[9] CMS, 2025 Medicare Advantage and Part D Advance Notice Fact Sheet (Jan. 31, 2024); https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-advance-notice-fact-sheet.
[10] Milliman, *State of the 2024 Medicare Advantage Industry: General enrollment plan valuation and benefit offerings* (Jan. 16, 2024); https://www.milliman.com/en/insight/state-of-the-2024-medicare-advantage-industry-general-enrollment.
[11] BRG, *MA Advance Notice Does Not Offset Rising Medical Costs and Could Lead to Reduced Healthcare Value for Beneficiaries* (Feb. 2024); https://media.thinkbrg.com/wp-content/uploads/2024/02/23124301/BRG-MA-Modeling-White-Paper-2024_Final.pdf.
[12] Id.

b. Access to Preventive and Other Necessary Care Was Reduced in 2024 for Enrollees with Complex Needs Due to the V28 Risk Adjustment Model and Will be Reduced Further in 2025 and Beyond

CMS states that the contoured implementation of V28 "is not expected to reduce access to preventive and other necessary care."[13] In fact, this impact is being observed now and should be publicly acknowledged and considered by CMS as reason to halt the continued phase-in of the V28 model in 2025.

We will shortly supplement this comment letter with additional data on our coalition members' observed impact of the new risk adjustment model on preventive care, patient panel sizes, care coordination, beneficiary cost-sharing and access, and supplemental benefits in 2024.

c. Clinical Analysis of V28 and Its Relation to Our Patients' Observed Health Status

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—thereby rewarding Medicare Advantage insurers to the extent that they achieve genuine efficiencies over traditional Medicare in addressing the same health conditions."[14]

The changes implemented in the V28 model work against this intent by disincentivizing MA plans from enrolling patients with certain conditions. One prevalent example of this is in diabetic patients with complications. There is significant variability in the cost of care for diabetic patients with and without complications. CMS rationalized their decision to constrain the weight of the multiple diabetes HCC groups with an example of a laboratory identified complications with minimal clinical significance. We do not believe this supports the need for constraint. Rather, it signals the potential need to remap individual ICD-10-CM codes across the HCC groups.

We agree with the decision to reclassify diabetes with hyperglycemia to a less severe HCC group, aligning with the HHS risk adjustment model. Recategorizing this complication of diabetes and simultaneously weighting all the diabetic HCC group coefficients the same, nullifies anything gained in the HCC group reclassification.

Major depression diagnosis codes for mild, unspecified, and in remission included in the V24 model HCC 59 were remapped to nonpayment HCC in the V28 model. We disagree with CMS's expectation that patients with "sufficiently serious" depression will be coded as moderate

[13] CMS, 2025 Medicare Advantage and Part D Advance Notice Fact Sheet (Jan. 31, 2024).
[14] *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).

or severe.[15] Most risk-bearing provider groups serve as Primary Care providers. It is unrealistic for Primary Care providers to know the highest level of ICD-10-CM specificity for all conditions encompassed within the ~74,000 ICD-10-CM codes. While coding specificity is the goal of Risk Model Principle 5, it is a tradeoff in fulfilling Principle 2 (predictive power of medical expenditures). If the goal of the V28 model is truly to "better direct resources to plans with beneficiaries with higher health care needs"[16] preserving the predictive power of Principle 2 should supersede Principle 5.

CMS's rationale for excluding angina pectoris (apart from unstable) from V28 model was due to diagnosis and coding variability.[17] Discrepancies between diagnostic criteria and coding criteria should be addressed in the annual revision of the ICD-10-CM codes not addressed through the application of a blanket solution to the risk adjustment model impacting all beneficiaries.

The complete removal of vascular disease, including PVD and PAD, presents insurmountable challenges as these conditions are prevalent among Medicare beneficiaries. Studies show that "PAD has significant impact on mortality; individuals with PAD have a two- to six-fold higher relative risk of death over a 10-year period versus the general population"[18] and "ten[%] of individuals over 60 years of age have PAD and the prevalence continues to increase with age."[19]

Additional conditions such as protein calorie malnutrition and atherosclerosis with intermittent claudication were removed from the V28 model due to CMS's belief that the differential coding patterns between MA and FFS for these conditions indicates discretionary coding variation (2024 Final Announcement, p.90). Comparing MA and FFS coding patterns inherently results in differentiation due to FFS provider groups narrow focus on Evaluation and Management (E/M) leveling and lack of provider training, education, and compliance oversight of ICD-10-CM specificity selection. Principle 2 states that "A primary purpose is to develop a system for risk-adjusting capitation payments to Medicare + Choice plans." We do not believe remapping these conditions to non-payment HCCs fulfills this primary purpose of appropriately predicting medical expenditures for these diagnostic categories.

d. <u>CMS Should Halt Further Phase-in of V28 in 2025</u>

In light of the evidence of negative impact to-date on beneficiaries' benefits, cost-sharing, and access to advanced primary care, CMS should cease any further implementation of the V28 HCC risk adjustment model pending public and transparent analysis of the extent of impact on

[15] CMS, 2024 Rate Announcement, p. 85.
[16] 2024 Announcement, p. 76.
[17] 2024 Announcement, p. 96.
[18] Chapter 96: Diagnosis and Management of Diseases of The Peripheral Arteries. (n.d.). Access Medicine.
[19] Criqui MH, Aboyans V, *Epidemiology of peripheral artery disease*, Circulation Research (April 2015).:

beneficiaries, particularly the impact on low-income special needs beneficiaries with access to advanced primary care. Implementation of V28 was finalized without independent or transparent validation of CMS' assertions about lack of impact on beneficiaries. In truth, as we are showing, all MA reductions are passed through to beneficiaries.

Value-based providers are willing to help improve the MA program and are doing so by accepting the current revenue reduction embedded in the blended V24-V28 model but it needs to be held fixed at 2/3-1/3 until more assessment on impact is completed and longer-term planning to survive the changes can be done.

Regardless of CMS's decision on continued implementation of the V28 model, CMS should return major depressive disorder, recurrent, mild (F33.0) and major depressive disorder, single episode, mild (F32.0) back into the risk model. To say that these codes do not require costs by removing them is clinically inaccurate and is harming beneficiaries by compromising the integrity of the risk model. Further, the diabetic HCC group coefficients should be returned to their original weights.

e. <u>Adverse Impact on Beneficiaries if V28 Phase-in Continues in 2025</u>

i. Frequent, Wild Swings in Revenue Discourage Investments in Infrastructure Needed to Make Value-Based Care Available to Beneficiaries

The reality is that the vast majority of value-based care and advanced primary care enjoyed by Medicare beneficiaries today is due to private investments. Medicare FFS continues to struggle with demonstration programs to identify a sustainable platform to offer advanced primary care with a focus on quality of care, provider performance and the patient experience. Such models are already being delivered to MA beneficiaries through advanced primary care platforms supported by private investment. However, that progress is put at risk when federal MA rates are reduced or do not keep up with utilization and cost trends.

For example, reports document that private investments in MA have dropped precipitously to a 6-year low.[20] Those investments will diminish further or cease in 2025 under continued V28 implementation. Appropriate incentives (i.e., stable, predictable federal funding) are a prerequisite to the private investments needed to make value-based care available to beneficiaries. The alternative to risk-assuming, entrepreneurial providers supported by private investment is standards FFS practices of limited physicians who lack resources for NP/PA staff support and tech infrastructure to enable patient engagement and patient follow-up. In fact, we are already observing some value-based care providers in our area shift to focus on FFS beneficiaries, decreasing access to providers for MA beneficiaries in a high penetration area and providing instead to FFS beneficiaries services that amount to less than advanced primary care.

[20] See Private Equity Stakeholder Project, pg. 11 (Jan. 2024). https://pestakeholder.org/wp-content/uploads/2024/02/PESP_Report_Medicare_Advantage_Feb2024.pdf.

Our coalition members have been working to increase the primary care physician base and inspire a new generation of medical students to select primary care as a career. It is projected that 28.56 million Americans will turn 65 between 2024 and 2030. As they age, their care needs will predictably increase. The revenue reductions from V28 undermine the ability and willingness to invest in the commitment to building the future workforce. The changes that will come from the planned next phase V28 roll out will reduce the size of the primary care workforce while demand for services will be increasing. The negative impact on access will be particularly hard felt in underserved areas of communities where support for transportation will be cut as is staffing, with no groups sitting in reserve seeking to move into those markets.

ii. More Physicians to Drop Medicare Patients

Numerous stakeholders express concern over an emerging shortage of Medicare primary care providers in the midst of the baby boom generation's senior years. The shortage of primary care physicians is projected to reach up to 48,000 by 2034.[21] Keep in mind that under the current reimbursement landscape, Medicare FFS payments, adjusted for inflation, declined 30% from 2001 to 2024.[22] This trend leads more physicians to abandon Medicare FFS. 65% of doctors won't accept new Medicare patients.[23] From 2016 to 2021, the number of primary care physicians billing Medicare declined each year, from 142,000 physicians in 2016 to 135,000 physicians in 2021.[24]

Cutting funding for providers who treat MA beneficiaries will accelerate the rate of physicians abandoning Medicare altogether. This is because physicians increasingly rely upon more favorable rates and arrangements under MA as a means to financially justify treating Medicare beneficiaries. If MA reductions are continued in 2025 and passed through from plans to providers, more of those value-based care providers will be unable to avoid losses in treating MA enrollees and will stop accepting Medicare. Eliminating MA as the last refuge from payment cuts for physicians treating Medicare beneficiaries will accelerate departure of physicians from the program and will make primary care provider shortages harder to ignore for policy makers.

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[21] See AAMC, *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034*, pg. 3 (June 2021); https://www.aamc.org/media/54681/download?attachment. Note: the current supply of new primary care physicians is not keeping up with need. Family Physicians have been more likely to become outpatient primary care physicians than Internal Medicine Physicians. There are 1,500 family physicians graduating from residency programs each year. Yet, there are more than 1,500 family physicians retiring from patient care each year.

[22] AMA, Medicare updates compared to inflation in practice costs (2001–2024) (Jan. 2024); https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf.

[23] Medscape, *Why Doctors Are Disenchanted With Medicare* (June 1, 2023); https://www.medscape.com/viewarticle/992642?form=fpf.

[24] Medical Economics, *Primary care physician numbers down as other clinicians increase from 2016 to 2021* (Aug. 1, 2023); https://www.medicaleconomics.com/view/primary-care-physician-numbers-down-as-other-clinicians-increase-from-2016-to-2021. ("Based on primary care physicians per 1,000 beneficiaries, the number dropped from 2.7 in 2016 to 2.3 in 2021.")

For physicians remaining with Medicare, their patients will see longer wait times due to increased patient panels which will strain providers' ability to effectively focus on patient experience and increase provider burnout.

IV. EFFECTIVE GROWTH RATE (SEC. A)

We strongly urge CMS to update the effective growth rate to appropriately reflect the documented increase in Medicare utilization and costs, including inflation. We are concerned that the proposed growth rates for 2025 do not fully account for the range of costs and increased utilization that should be included in the growth percentages, particularly considering the impact of inflation.

When compared to available metrics that measure Medicare costs and medical inflation, the 2.44% is not in line with available data. Specifically, the proposed effective growth rate is well below the Medicare Trustees' projected 5.80% growth in per beneficiary Medicare costs in 2025.[25] The CMS Office of the Actuary figures are also inconsistent with the effective growth rate, stating that Medicare spending per beneficiary growth is anticipated to be 5.60% in 2025.[26]

We see numerous public reports indicating that MA plans have recently experienced significantly higher utilization and cost trends and expect these trends to continue throughout 2024 and beyond.[27] Such trends reported by plans reflect what our coalition members observe at the provider level. Other reports suggest sustained higher cost trends in additional markets.[28]

We note that CMS' own data, as shown in the Advance Notice, also reflects higher cost growth in 2023 – 7.2% growth in the non-ESRD FFS USPCC and 6.9% growth in the non-ESRD Total USPCC. Similarly, the Medicare Trustees, in their 2023 report, projected per beneficiary cost growth of 6.1% for 2023. Importantly, the Trustees project per beneficiary cost growth of 4.8% and 5.8% for 2024 and 2025, respectively.[29]

We also are concerned about the lack of transparency into CMS' analysis and assumptions used to calculate the growth percentages. We continue to request transparency on how the growth percentages were developed, and that CMS provide any analysis, explanation, and methodologies the agency utilized.

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[25] Centers for Medicare & Medicaid Services: *2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (2022): https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf.

[26] https://www.cms.gov/files/document/release-presentation-slides-national-health-expenditure-projections-2022-31-growth-stabilize-once.pdf.

[27] See, for example: https://finance.yahoo.com/news/cvs-health-corporation-nyse-cvs-150040535.html; https://finance.yahoo.com/news/humana-inc-nyse-hum-q4-165223864.html.

[28] See: https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html.

[29] Medicare Trustees, 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Mar. 2023); https://www.cms.gov/oact/tr/2023.

V. 2025 Proposed and Alternative RxHCC Models

We are supportive of the Alternative RxHCC Model published in the Advance Notice - 2025 RxHCC Model Relative Factors (2018/2019 calibration). We believe a model calibrated on the two most recent years not impacted by the COVID-19 pandemic, 2018 diagnoses and 2019 expenditures, is the better predictor of gross drug spending between the two models proposed in the 2025 Advance Notice. CMS included Special Needs Plans (SNPs) when determining the Part D normalization factor proposed in the 2025 Advance Notice, however, it excludes these plans when determining the National Average Bid Amount. This variance should be explicitly addressed by CMS with opportunity for stakeholder comment.

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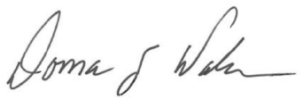
Thank you for your attention to these comments on the Advance Notice. We remain available to answer any technical questions that may arise out of these comments. Please feel free to reach us at Donna.Walker@inhealthmd.com or Phall@ebglaw.com.

Respectfully,



Donna Walker
President

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Meena Seshamani, Director, Center for Medicare
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