



April 22, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Slavitt:

On behalf of AMGA, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) "March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting, Discussion Paper."

AMGA, founded in 1950, represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Our member medical groups participate in many if not all state marketplaces. AMGA, therefore, has a strong interest in how CMS is considering improving risk adjustment for non-grandfathered marketplace plans in the individual and small group market.

AMGA's comments address four of the six improvement topics discussed in chapter 4. We also respond to the agency's mention of the use of socioeconomic and sociodemographic factors in risk adjustment.

Partial Year Enrollment

AMGA members are well aware of so called "hit and run" plan enrollees, namely those that enroll, have a high-cost episode, and effectively dis-enroll from a marketplace plan. In its preliminary analysis, CMS states, "partial year enrollment . . . did not appear to reflect noticeably higher costs associated with partial year enrollees." However, the agency recognizes its modeling "may not fully reflect the experience of some commenters, because we continue to conduct our modeling on a commercial data set, with largely employer plans, which may not reflect the unique enrollment duration and health status of the individual and small group markets." We share this concern. Therefore, AMGA encourages CMS to consider, as the paper states, "a hybrid approach combining enrollment adjustment factors and separate models." That is, "where selected HCCs [Hierarchical Condition Categories] are determined by their sensitivity to the separate, partial year models' predicted parameters or coefficients" and where the agency bases HCCs' sensitivity to enrollment duration of 1-4 months, 5-8 months and 9-12 months.

Prescription Drug Modeling

The white paper discusses at length adding prescription drug utilization as a risk adjustment marker.

CMS states prescription drug utilization data can, among other things, "fill in the gaps where diagnoses may be missing due to under-recording in medical claims or encounter data." In addition, "drug data can be available more quickly," "reduces the incentive for plans to restrict access to medications," and can offer "a more complete picture of the severity of illness." CMS recognizes modeling prescription drug use can also create perverse incentives. For example, it may incentivize providers to prescribe drug versus non-drug treatments or to over-prescribe to yield higher reimbursements. CMS also recognizes physician prescribing behavior varies, lower-income enrollees use drugs at a lower rate, and many drug classes are used "off label." As a result, utilization can have very different expenditure implications.

CMS proposes four conceptual modeling approaches to account for prescription drugs. The agency could impute risk regardless of how a disease condition is identified, i.e., by either diagnosis or by drug utilization. The agency could model by severity. Only if a drug class and a specific diagnosis are present would the model predict incremental costs beyond the diagnosis alone. A third approach would take a drug (or "Rx") dominant approach, whereby when a drug is utilized a diagnosis is imputed "so the predicted expenditures should be the same irrespective of whether the diagnosis is reported." A fourth method, which CMS terms "flexible/generalized," is a hybrid approach that allows for "different predictions for diagnosis only, drug only, and both diagnosis and drug groups."

AMGA agrees with the agency's assessment "prescription drug data in the HHS-HCC risk adjustment framework deserves consideration." We also agree the "revision would need to be carefully designed and implemented," that "it is difficult to identify specific drug utilization indicators that can unambiguously improve model performance without raising new concerns about incentives and fairness" and "gains in model predictive accuracy" may best arise "from identifying individuals utilizing expensive drugs." Therefore, we believe CMS should start incrementally by examining a finite number of expensive drug classes preferably using the "flexible/generalized" approach. This may be the best method to provide timely and accurate capture of prescription drug utilization.

High Risk Enrollee Pooling in HHS Risk Adjustment

The white paper recognizes, as has the Medicare Payment and Advisory Commission (MedPAC) and others, risk adjustment "underpredicts the costs of people whose costs are far above average." Therefore, AMGA believes CMS should consider further "reducing issuers' exposure to outliers via modifications to the HSS risk adjustment model." This means excluding enrollees with a percent of costs above a certain threshold. Based on the example CMS provides at page 70, the agency is concerned, however, this may cause issuers to take steps to "avoid the high-cost individuals in any particular [diagnosis] category," which would negatively affect patients, and may leave smaller issuers "vulnerable to unpredictable costs." CMS already is pursuing this policy in the Medicare Shared Savings (ACO) Program. CMS truncates an assigned ACO's beneficiary's total annual Parts A and B fee-for-service per capita expenditures at the 99th percentile of national Medicare Fee-For-Service expenditures as determined for each benchmark year. AMGA believes a similar approach, i.e., accounting for outliers, or where enrollee-level plan liability is limited to a certain cost threshold, could be helpful. The white paper identifies a threshold of approximately \$1 million. To execute the policy CMS would "calculate an additional [dollar] transfer amount for each issuer" and transfer these moneys using the existing risk adjustment transfer process between and among plans.

Concurrent versus Prospective Modeling

CMS explains the agency's use of concurrent assignment was based on the practical reality that a prospective model "was infeasible due to lack of previous year information on health status [diagnoses]." CMS also notes because "enrollees move in and out of enrollment in the individual and

small group markets," a prospective model could not predict "unsystematic risk," such as acute costs resulting from, for example, strokes and heart attacks. CMS also endorses the use of a concurrent model because it "supports the intent of the Affordable Care Act - encouraging choice, competition, and growth in plans." All this makes sense. However, as is well known, the agency uses prospective modeling for Medicare Advantage and Medicare Part D, which is noted on page 8 of the white paper. We question whether continuing indefinitely with a concurrent model makes sense, particularly as the individual and small group markets mature or stabilize. We also question the logic of Medicare's use of two different risk adjustment models. If the concurrent model has better "predictive power" because concurrent risk explains more of the "variation in current (acute) costs," CMS may want to consider using the model in the Medicare program, or risk adjustment using the concurrent model for some subset of Medicare beneficiaries.

Including Socioeconomic and Sociodemographic Factors in Risk Modeling

While the white paper does not discuss in any detail, CMS does mention the use of socioeconomic and sociodemographic factors in risk adjustment. "In the longer term," CMS notes at page 35, "we would like to explore the possibility of using socioeconomic status or other sociodemographic factors as predictors in the risk adjustment model." We encourage CMS to do so. The research shows there is an empirical relationship between socioeconomic status, race and ethnicity, and health care outcomes. Based on the National Quality Forum's "Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors" 2014 technical report, AMGA also recommends CMS work toward risk adjusting outcome performance measures.

Thank you for your consideration of our comments. AMGA would be happy to discuss these further. Please contact David Introcaso, Ph.D., Senior Director, Regulatory and Public Policy at 703.838.0033, extension 335, or via dintrocaso@amga.org, with any questions.

Sincerely,



Donald W. Fisher, Ph.D.
President and CEO