STATEMENT FOR THE RECORD

Submitted to the
House Energy and Commerce Committee
Subcommittee on Health

"MACRA and Alternative Payment Models: Developing Options for Value-based Care"

November 8, 2017

America's Health Insurance Plans
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Washington, D.C. 20004

America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for the American people.

Value-Based Agreements Improve Health Care for Medicare Beneficiaries

We thank the committee for focusing on the role of Alternative Payment Models (APMs) in providing incentives for high quality, cost-effective patient care under the "Medicare Access and CHIP Reauthorization Act of 2015" (MACRA).

Through their participation in the Medicare Advantage (MA) program, our members are strongly committed to serving Medicare beneficiaries. MA health plans have a long track record in emphasizing prevention, providing access to disease management services for chronic conditions, and offering systems of coordinated care for ensuring that beneficiaries receive the health care services they need.

Unlike the traditional Medicare program, MA plans often offer additional, comprehensive benefits such as vision, dental, and hearing coverage, as well as a cap on out-of-pocket spending, and many plans offer drug coverage with no additional cost to beneficiaries. In addition, in comparison to the traditional Medicare program, MA has been shown to reduce hospital readmissions[1] and institutional post-acute care admissions[2], and increase rates of annual preventive care visits[3] and screenings.[4] As a result, the MA program has a beneficiary satisfaction rate of 90 percent.[5]

Value-based agreements are an important strategy used by MA plans to improve health care for Medicare beneficiaries. These agreements are designed to ensure that patients receive the greatest possible value for every dollar spent on their care. Through them, doctors, health care institutions,

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[1] Lemieux, Jeff, Sennett, Cary, Wang, Ray, Mulligan, Teresa, Bumbaugh, Jon. Hospital readmission rates in Medicare Advantage plans. *American Journal of Managed Care* 18(2): 96-104. February 2012.
[2] Huckfeldt, Peter J., Escarce, Jose J., Rabideau, Brendan, Karaca-Mandic, Pinar, Sood, Neeraj. Less intense post-acute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service. *Health Affairs* 36(1): 91-100. January 2017.
[3] Sukyung, Chung, Lesser, Lenard I., Lauderdale, Diane S. et al. Medicare annual preventive care visits: Use increased among fee-for-service patients, but many do not participate. *Health Affairs* 34(1): 11-20. January 2015.
[4] Ayanian, John Z., Landon, Bruce E., Zaslavsky, Alan M., et al. Medicare beneficiaries more likely to receive appropriate ambulatory services in HMOs than in traditional Medicare. *Health Affairs* 32(7): 1228-1235. July 2013.
[5] Morning Consult National Tracking Poll. March 11-16, 2016.

and health insurance providers come together to focus on one goal: helping the patient achieve their best health for the long term.

A recent study, published in February 2017 by the *American Journal of Managed Care*, found that these initiatives have been successful. By delivering care in ways that focus on value, MA plans have increased the use of preventive health care services, increased physician office visits, reduced both emergency department visits and inpatient hospital admissions, and increased the lifespan for MA enrollees.[6]

Specifically, for beneficiaries who received care from providers in value-based agreements:

- Beneficiaries were almost 3 times more likely to undergo preventive care visits;
- Women age 74 and younger were 28 percent more likely to undergo screening mammography;
- Emergency department visits were reduced by 11.2 percent and inpatient hospital admissions were reduced by 11.9 percent; and
- The overall survival rate was 6 percent higher than for other beneficiaries and the hazard of dying was 32.8 percent lower.

The benefits of providers contracting with MA plans are further demonstrated by a study published by *Health Affairs* in September 2016. This study presented data showing that the innovative techniques employed by MA plans have a spillover effect that has contributed to the recent slowdown in national Medicare FFS spending.[7] Specifically, the study shows that in counties with high baseline MA penetration rates, each 10 percentage point increase in MA penetration was associated with a decrease in per capita FFS spending of $154 annually (nearly 2 percent).

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[6] Mandal, Aloke K., Tagomori, Gene K., Felix, Randell V., Howell, Scott C. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. *American Journal of Managed Care* 23(2): e41-e49. February 2017.

[7] Johnson, Garret, Figuero, Jose F., Zhou, Xiner, Orav, E. John, Jha, Ashish K. Recent growth in Medicare Advantage enrollment associated with decreased fee-for-service spending in certain US counties. *Health Affairs* 35(9):1707-1715. September 2016.

MA Plans Can Provide Value as Advanced APMs

As Congress examines the implementation of MACRA and the role of APMs, AHIP supports a demonstration that would allow clinicians to receive credit under the Medicare Advanced APM rules for participating in financial risk-based arrangements with MA plans.

In a final rule on MACRA issued last week, the Centers for Medicare & Medicaid Services (CMS) signaled its intention to test the effect such a demonstration would have in expanding incentives for eligible clinicians. We applaud CMS for taking this approach, and we look forward to working with the agency to design and implement the demonstration.

In August 2017, AHIP addressed the attached letter to CMS outlining our guiding principles for designing a voluntary MA Advanced APM Incentive Demonstration Program. Our principles focus on: (1) establishing the basic structure of the demonstration; (2) supporting the infrastructure that is needed to transition to risk-based payment arrangements; (3) designing a demonstration that is budget neutral and also enhances quality; (4) developing an attestation process through which clinicians could indicate the percent of payments, or patients, associated with qualifying MA payment arrangements; and (5) preserving Medicare's non-interference clause to ensure that CMS cannot dictate pricing or contract terms between MA plans and their network providers.

These principles, as discussed in our comment letter, are essential for ensuring that the CMS demonstration program effectively levels the playing field to provide equal incentives for providers under both the MA and FFS programs. Such a demonstration would recognize and reward the successful, innovative practices that MA plans and providers have already developed together to better serve their patients. It also would ensure that the MA program continues to deliver better care, improved health, and lower costs for Medicare beneficiaries.

We thank the committee for considering our perspectives on the merits of establishing an MA Advanced APM Incentive Demonstration Program. We look forward to working with you as Congress continues its oversight of MACRA and other Medicare issues.

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August 21, 2017

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Submitted electronically via http://www.regulations.gov

Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

America's Health Insurance Plans (AHIP) is writing on behalf of our members in response to the Centers for Medicare & Medicaid Services' (CMS) Notice of Proposed Rulemaking for the Medicare Program; CY 2018 Updates to the Quality Payment Program (QPP). AHIP is the national trade association representing health insurance plans. Our members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

AHIP appreciates CMS' efforts to solicit feedback on the proposed changes for year two of the QPP. In general, AHIP is supportive of efforts to alleviate administrative burden to encourage clinician participation in the Merit-based Incentive Payment System (MIPS) and a transition path to Advanced APMs. We also strongly support CMS' consideration of a demonstration that would allow clinicians to receive credit under the Medicare Advanced APM rules for financial risk based arrangements with Medicare Advantage (MA) plans. Our recommendations concerning such a demonstration and select proposals in the Notice of Proposed Rulemaking are below. We look forward to working with CMS to develop the demonstration.

I. MIPS in QPP Year 2

Low Volume Threshold for MIPS Eligibility

In the current year, or 2017 transition year, of the MIPS program, clinicians with less than or equal to $30,000 in Part B allowed charges or who provide care for 100 or fewer Part B beneficiaries are excluded from MIPS. CMS has stated that any clinicians or groups who are excluded from MIPS may still voluntarily participate in MIPS and are not subject to the MIPS payment adjustment. Beginning with the 2018 performance year, CMS is proposing to increase this low-volume threshold to allowed charges of less than or equal to $90,000 or 200 or fewer Part B beneficiaries. CMS believes this will likely exclude 134,000 additional clinicians from MIPS from the approximately 700,000 clinicians that would have been eligible based on the low-volume threshold that was finalized in the CY 2017 QPP final rule.

Comments:
AHIP supports CMS' continued focus on the creation of pathways for small group practices to successfully participate in MIPS. We believe some of the proposed changes described below will help continue to move the program in the right direction.

AHIP, for example, supports modification to the low volume threshold to exclude small groups, rural practices and practices in Health Professional Shortage Areas (HPSAs) from MIPS, but still allow them to voluntarily participate in MIPS without being subject to potential negative payment adjustment.

Although AHIP supports the public dissemination of MIPS data, it is important that the information be released in a form that is convenient and simple to understand for all health care stakeholders. To that end, we encourage CMS to work closely with stakeholders to develop templates, draft language, etc. to ensure the public at-large can easily decipher, digest, and use this important information. Additionally, performance data must be presented in a format that is understandable by the provider. For example, CMS could consider developing standardized summary reports and delivering them to providers along with detailed supporting data.

Additionally, we are supportive of the proposal that allows clinicians and groups who might otherwise be excluded from MIPS based on not meeting either the threshold for Part B allowed charges or attributed Medicare patients, but who exceed one of these low-volume thresholds, to still choose to

participate in MIPS and be subject to the MIPS payment adjustments. Given the change in low volume threshold in year two, we suggest CMS allow providers who exceed both thresholds to still voluntarily participate in MIPS and be subject to the MIPS payment adjustment.

Virtual Groups

CMS is proposing that beginning in 2018 small provider groups would have the option to report as "virtual groups" for year 2 and beyond. Additionally, CMS has more specifically defined a virtual group as a combination of two or more TINs composed of a solo practitioner or a group with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period for a year. CMS states that providing these additional flexibilities and reduction in barriers will further enhance the ability of small practices to participate successfully in the QPP.

Comments:
AHIP supports the implementation of virtual groups as a way to accommodate small practices and practices in rural or HPSAs, and agrees with the proposal to define a virtual group as a solo practitioner or a group with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period for a year. This will allow small practices to more easily form a virtual group and begin MIPS participation.

We suggest CMS provide additional information regarding reporting requirements for virtual groups. Specifically, we suggest CMS require all members of a virtual group to report on the same measure set, which would allow CMS to more easily calculate performance against measures.

We also continue to support the idea of providing technical assistance to MIPS eligible clinicians in small practices, rural areas, or to clinicians practicing in HPSAs, as this will help them be successful in MIPS.

Performance Period

In the 2017 transition year, CMS is requiring a minimum 90-day performance period for the categories of Quality, Advancing Care Information, and Improvement Activities. The Cost category is currently measured on a 12-month performance period. CMS is proposing to require a 12-month performance

period for the Quality and Cost categories and continue the 90-day performance period for Advancing Care Information and Improvement Activities.

Comments:
AHIP supports the proposal for the 12-month performance period for the Quality category, as we believe the current 90-day performance period is not sufficient for clinical practices to thoroughly diagnose performance, make practice improvements and re-assess to gauge effectiveness of improvement activities. CMS should consider a longer performance period for the Improvement Activities category as well, given that a key MIPS strategic goal is process implementation that drives movement toward delivery system reform and continued quality improvement.

Additionally, we encourage CMS to look for ways to narrow the gap between the performance period and the payment period for the QPP program. By more closely coupling reporting to payment periods, e.g. instituting a 6-month gap, CMS will allow physicians to better understand the performance and payment link as well as implement the necessary steps to improve processes based on more recent information about their performance.

Performance Threshold

In the 2017 transition year, CMS requires a minimum of 3 points be achieved for clinical practices participating in MIPS to avoid a negative payment adjustment. CMS also requires practices achieve between 4 and 69 points to achieve a positive adjustment and 70 or greater points to be eligible for an exceptional performance bonus. For year 2 of the QPP, CMS is proposing to increase the performance threshold from 3 points to 15 points, while keeping the additional (exceptional) performance threshold at 70 points. CMS believes moving the performance threshold to 15 points represents a meaningful increase in the performance threshold that will drive quality improvement while maintaining flexibility for MIPS eligible clinicians in the pathways available to achieve this performance threshold.

For example, clinical practices can achieve 15 points by:

- Reporting all required improvement activities.
- Meeting the advancing care information base score and submit 1 quality measure that meets data completeness.
- Meeting the advancing care information base score, by reporting the 5 base measures, and submit one medium weighted improvement activity.
- Submitting 6 quality measures that meet data completeness criteria.

Comments:
AHIP supports the change in performance threshold.

Facility Based Measurement

As a new proposal for year two of the QPP, CMS is proposing to implement a voluntary facility-based scoring mechanism, which would be based on the current Hospital Value Based Purchasing Program and be available to facility-based clinicians who have at least 75% of their covered professional services supplied in the inpatient hospital setting or emergency department. The facility-based measurement option will convert a facility Total Performance Score into a MIPS Quality performance and Cost performance score.

Comments:
AHIP supports the proposal, as this will allow clinicians who mainly treat patients in a facility setting to still be eligible to participate in the QPP.

Quality Performance Category

Under the 2017 QPP final rule, for the 2019 payment year, CMS requires a 50% data completeness for quality measures, with measures that do not meet the data completeness criteria receiving a maximum of 3 points. The final rule also provided that the data completeness threshold would increase to 60% for the 2018 MIPS performance period. In addition, CMS is not currently incorporating a performance improvement (year over year) factor.

CMS is proposing to delay the increase in the data completeness threshold. Under the proposal, the 50% threshold would apply to the 2018 performance year and not increase to 60% until the 2019 performance year. Additionally, for the 2018 performance year CMS is proposing that any measures that fail data completeness receive only 1 point instead of 3 points, with the exception of small practices, which will continue to receive 3 points. Finally, an improvement in quality performance would be incorporated into the scoring in the 2018 performance year.

Comments:
AHIP supports these proposed changes. In addition, we continue to encourage CMS to adopt more outcome measures, including patient-reported outcomes, and medication adherence measures beyond those that are currently included in PQRS, VM and EHR Incentive Program.

Cost/Resource Use Performance Category

Under the 2017 QPP final rule, the Cost performance category counts for 0% of the final score in the 2017 performance period/2019 payment year, but will count for 10% in the 2018 performance period/2020 payment year and 30% in the 2019 performance period/2021 payment year. For 2017, this performance category includes the total per capita costs for all attributed beneficiaries measure, the Medicare Spending Per Beneficiary (MSPB) measure, and ten episode-based measures, with no incorporation of a performance improvement factor.

CMS is proposing that the Cost performance category remain at 0% of the final score in the 2018 performance period/2020 payment year (rather than increase to 10%) before going up to 30% in the 2019 performance period/2021 payment year. Additionally, CMS is proposing to keep the total per capita costs and MSPB measures but not use the original ten episode-based measures for the 2018 performance period. CMS instead will work on developing new episode-based measures with clinician input for future performance periods. Lastly, CMS is considering including an improvement factor in the cost performance category.

Comments:
AHIP continues to support the measurement and assessment of clinician performance on Cost / resource use and we recommend CMS increase weighting and emphasis on performance in this category, as we believe that such an emphasis is critical to driving value and affordability of healthcare. Requiring the transitioning from a weight of 0% to a weight of 30% over the course of just one year is extreme, would present an additional challenge for physicians, and would help accomplish the goal of encouraging providers towards Advanced APMs, where understanding cost and risk is a critical component.

Additionally, AHIP recommends consideration be given to cost measures that go beyond assessing whether there is waste in the system, and that seek to promote clinically-appropriate utilization of healthcare services, including for those clinicians who serve a significant portion of the frail and elderly population.

Lastly, we ask CMS to consider episode groupers for chronic conditions that do not have an inpatient trigger, so that costs for chronic conditions can be included even if an inpatient stay does not occur (i.e., management of diabetes).

Improvement Activities Performance Category

CMS is not proposing changes to the weighting or number of activities required to achieve full credit for the Improvement Activities category. However, CMS is proposing to add activities clinicians can choose from, including consulting Appropriate Use Criteria (AUC) through a qualified clinical decision support mechanism when ordering advanced diagnostic imaging services.

Comments:
AHIP continues to support the use of AUC for advanced diagnostic imaging services in the Medicare program. We continue to support CMS' intent to establish standards for clinical decision support mechanisms (CDSMs) that focus on the functionalities that a qualified CDSM should be able to perform, allowing for growth and innovation and promoting choices that fit into physician workflows and build on existing CDS infrastructures.

Advancing Care Information Performance Category

In the final 2017 QPP rule, the Advancing Care Information performance category counts for 25% of the total score. In addition, clinicians are permitted to use either the 2014 or 2015 Certified Electronic Health Record Technology (CEHRT) Edition for the 2017 transition year but are required to use 2015 CEHRT Edition for 2018.
Although CMS is not proposing changes to the weighting of this performance category, they are proposing to allow clinicians to use either 2014 or 2015 CEHRT Edition for 2018. Additionally, CMS would grant a bonus to clinicians for using 2015 CEHRT Edition. CMS is also proposing to add a significant hardship exception for MIPS-eligible clinicians in small practices.

Comment:
AHIP supports CMS in its proposal to afford practices additional flexibility in the use of 2014 CEHRT given the time and resources required for practices to upgrade. We also support the additional consideration being given to MIPS-eligible clinicians in small practices.

However, for future performance years, CMS should consider increasing the overall weighting and strengthening the requirements of this category by emphasizing patient outcomes, patient engagement, and care coordination.

Finally, we encourage CMS to continue their work with the Office of the National Coordinator for Health IT (ONC) on interoperability, with the ultimate goal of requiring all clinicians to use the same Edition Health IT Certification Criteria in order to improve interoperability, consistency of reporting, and consistency across providers.

Final Score Bonus for Small Groups

CMS is proposing to add a bonus of five points to the final score for MIPS eligible clinicians who participate in MIPS for the 2018 MIPS performance period and are in small practices or in a virtual group or an APM entity with 15 or fewer clinicians (the entire virtual group or APM entity combined must include 15 or fewer clinicians to qualify for the bonus). CMS has indicated that a bonus of 5 points is appropriate to acknowledge the challenges small practices face in participating in MIPS and to help them achieve the performance threshold of 15 points for the 2020 MIPS payment year.

Comments:
AHIP supports CMS in considering small practices and allowing for a pathway for these practices to participate in MIPS. However, offering numerous and overlapping bonuses complicates an already complex program and reduces the significance of a bonus. Instead of offering a bonus to incentivize participation, the needs of clinicians, particularly those in small practices, are better served by technical assistance that promotes movement to value and accountability, as well as thoughtful evaluation and adjustment.

CMS may wish to employ a "small group" performance benchmark for applicable performance categories, as an alternative way to provide considerations for small groups, as this will allow for points to be awarded based on performance rather than practice characteristics.

II. Advanced APMs in QPP Year 2

Clinician Cap for Medical Home Advanced APMs

Under the CY 2017 final rule, beginning in 2018, the Medical Home Model Advanced APM financial risk standard does not apply for APM Entities that are owned and operated by organizations with more than 50 eligible clinicians. CMS is proposing to exempt Round 1 participants in the CPC+ Model from the 50-eligible clinician cap since the clinician cap was finalized after CPC+ Round 1 participants had signed agreements with CMS.

Comments:
We understand the need to exempt Round 1 participants in the CPC+ Model from the 50-eligible clinician gap, given the timing of the final rule and CPC+ Round 1 participation agreements. However, we would also like to reiterate our previous recommendation that CMS use patient panel size attributed to the medical home rather than clinician count for the application of these standards. While we support flexibility for smaller entities, such an approach will help promote consistency between the definitions under MACRA and those used by CMS in determining specific program requirements.

Additionally, we support CMS's proposal that the financial risk standards for Other Payer Medical Homes would be identical to and aligned with the Medicaid Medical Home Standard. For example, utilizing the suggested alignment, CPC+ organizations would not be limited by their ability to qualify for Advanced APMs based on the size threshold and could be assessed using the Medical Home Model Financial Risk Criteria.

Nominal Financial Risk Amount Standard for Other Payers/All Payer Combination Option

In the CY 2017 MACRA final rule, CMS finalized a nominal financial risk amount standard for Other Payers under the All Payer Combination Option as follows:

- Marginal risk of at least 30%;
- Minimum loss rate of no more than 4%; and
- Total risk of at least 3% of the expected expenditures for which the APM Entity is responsible

CMS is proposing to add the 8% revenue-based standard, which applies to Medicare Advanced APMs under the 2017 final rule, as an alternative to the 3% expenditure-based standard. This change would align with the nominal amount standard for Medicare Advanced APMs.

Comments:
We have previously expressed concern that, contrary to the stated goals of alignment across Advanced APMs and Other Payer Advanced APMs, the marginal risk rate and minimum loss rate standards were eliminated for Advanced APMs yet retained for Other Payer Advanced APMs in the MACRA final rule for CY 2017. We understand that currently designated Advanced APMs under the Medicare Option already meet the marginal risk and minimum loss standards – and that CMS intends that all future Advanced APMs under the Medicare Option meet them as well. We believe it is important for

Advanced APMs under the Medicare Option to have the same nominal financial risk amount standard as Advanced APMs under the Other Payer Option to promote consistency, alignment, and a level playing field. While we support adding the 8% revenue-based standard as an option for meeting the total risk criteria as it is consistent with the standard for Medicare Advanced APMs, there is still a discrepancy between the standards, as articulated under MACRA regulation, with the elimination of the marginal risk and minimum loss rates for Medicare Advanced APMs. We believe that lack of alignment between Medicare and other payer requirements in nominal financial risk standards creates an unlevel playing field and we strongly encourage CMS to align the nominal financial risk standards for Advanced APMs and Other Payer Advanced APMs.

Additionally, we continue to believe that there should be a separate pathway to determine whether Medicaid APMs are Other Payer Advanced APMs given states' varying degrees of progress in adopting APMs. CMS should provide maximum flexibility in the design of Medicaid APMs, especially for determining financial risk. Medicaid providers typically receive lower reimbursement rates but are more likely to treat a higher proportion of high-risk and complex patients, and may not be able or prepared to accept the same levels of financial risk for their Medicaid business as other providers.

QP Determinations for All Payer Combination Option

Under the CY 2017 MACRA final rule, Qualifying APM participant (QP) determinations under the All-Payer Combination Option are made at either the APM Entity or individual eligible clinician level, depending on the circumstances. In this proposed rule, CMS is proposing that QP determinations under the All-Payer Combination Option would be calculated at the individual eligible clinician level only. CMS' rationale is that they are trying to account for the fact that participation in APMs will vary across payer and that eligible clinicians in the same APM Entity group would not necessarily have agreed to share risk and rewards as an APM Entity group.

Comments:
We believe CMS should offer a flexible approach that allows for QP determinations to be made at the group level when the structure of the group aligns for an Advanced APM and an Other Payer APM. We recognize that this approach may not account for the variety of organizational structures that exist outside of a group-level structure, hence the need for a flexible approach that can accommodate QP determinations at the individual eligible clinician level as well.

Determination of Other Payer Advanced APMs

In the CY 2017 final rule, CMS laid out a process under which, to be assessed under the All-Payer Combination Option, APM Entities or eligible clinicians would have to provide CMS with information regarding their payment arrangements with Other Payers, including the amount of revenues for services furnished through the arrangement, the total revenues from the Other Payer, the number of patients furnished any service through the arrangement, and the total number of patients furnished any service through the Other Payer. In addition, the APM Entity or eligible clinician would have to submit to CMS an attestation from the Other Payer that the submitted information is correct.

CMS is proposing that the requirement for attestation from the Other Payer be eliminated. Instead, APM Entities or eligible clinicians would need to certify information they submit. In addition, CMS is proposing to add a voluntary "payer-initiated" process starting in 2018. Under this option, payers could submit payment arrangement information for Medicaid (including both Medicaid fee-for-service and health plan arrangements), Medicare health plans (including MA plans, Medicare-Medicaid plans [MMPs], cost plans, and Programs of All-Inclusive Care for the Elderly [PACE] plans) and Center for Medicare & Medicaid Innovation (CMMI) multi-payer models for CMS to decide on regarding whether the arrangements qualify as Other Payer Advanced APMs. For Medicare health plans, CMS is proposing that information be submitted during the annual bidding process. Regarding Medicaid, CMS is proposing that any state and territory may request that the agency determine whether payment arrangements qualify and that the submission window would be between January 1 and April 1 of each year. This payer-initiated option would be offered to other payer types, including commercial and other private payers, starting in 2019 prior to the 2020 All Payer QP Performance Period.

Comments:
We support the proposal to add a voluntary "payer-initiated" process, beginning with the 2019 performance period, and urge CMS to maintain the voluntary nature of this pathway. Additionally, we recommend CMS open the payer-initiated process to other payer types, including commercial and other private payers, starting in 2018 for the 2019 performance period rather than waiting until 2019 for the 2020 performance period. Since the 5% bonus payment is time-limited to 6 years, delaying the ability to count commercial arrangements removes a significant portion of the bonus benefit. A delay could also further impede the transition to value-based care for Medicare, unnecessary constraining participation and working against CMS' goal to encourage providers to join advance APMs.

Given that this option will allow certain other payers, including payment arrangements authorized under Medicaid, MA, and CMMI multi-payer models, to request that CMS determine whether their other payer arrangements are Other Payer Advanced APMs starting prior to the 2019 All-Payer QP Performance Period, it is critical that CMS develop the submission form and the additional guidance CMS intends to offer regarding the payer initiated process and make both available to payers as soon as possible with an opportunity and sufficient time for public comment. Moreover, we are concerned with CMS' proposal to wait until the annual bid process and recommend that CMS. should provide for a rolling certification process for all payers, so that payers may submit Advanced APM determination requests throughout the year prior the performance period and that CMS certify APMs for three years if the payer attests that the contract will not change, given that many APM contracts are multi-year so as to foster a sustained partnership.

We would also like to reiterate our concern, originally stated in our 2016 comment letter, regarding the potential scope of the required information, particularly since the proposal contemplates some payer competitively-sensitive information being provided by APM entities or eligible clinicians (through the eligible clinician initiated process). While we appreciate CMS' intent to avoid dissemination of potentially sensitive contractual information and to keep information confidential to the extent permitted by federal law, even with such protections, there are still risks of disclosure. As such, we recommend that the information required be limited to the minimum data necessary to achieve the purpose of assessment. In addition, we strongly recommend that the information be pre-designated as falling under Exemption 4 of the Freedom of Information Act and not be shared with other agencies or used for any purposes other than the determination of whether a putative QP meets the threshold. We also urge CMS to provide assurance that the limited information to be posted on the CMS website will not be expanded without further rulemaking.

Additionally, we strongly recommend that CMS permit Medicaid plans to submit arrangements for Advanced APM determinations instead of only allowing submission by states. States do not have the capacity to be solely responsible for Advanced APM submissions to CMS on behalf of Medicaid plans. We believe Medicaid managed care plans that are working and contracting with providers are best positioned to submit timely and accurate Advanced APM requests.

Finally, we urge CMS to allow for flexibility for Medicaid provider Advanced APMs. Medicaid providers are often already paid in a way that resembles the assumption of risk; as such, requiring additional risk or burdensome requirements could reduce the ability to include Medicaid Advanced APMs in MACRA. As mentioned previously, CMS should provide maximum flexibility in the design of

Medicaid APMs, especially for determining financial risk. We urge CMS to ensure that implementation of the Other-Payer Advanced APMs does not adversely impact provider participation in Medicaid, and instead promotes participation by creating new incentives and reducing administrative burdens for Medicaid-participating providers.

MA Plans as Advanced APMs under the Medicare Option

Under the current MACRA rule, MA plans are treated as Other Payers, and payments and patients attributable to MA plans cannot be counted toward QP determinations under the Medicare Option. Clinicians taking risk in a contract with an MA plan are only eligible to receive credit for their participation through the All-Payer Combination Option beginning in payment year 2021.

In the proposed rule, CMS indicates that the agency is considering and welcomes comments on using its waiver and demonstration authorities to allow eligible clinicians to receive credit toward QP determinations for their risk-based arrangements with MA plans under the Medicare Option.

Comments:
AHIP commends CMS for considering and soliciting ideas on creating a way for individual clinicians and clinician groups to receive credit for their financial risk based arrangements with MA plans. Value-based contracts between MA plans and providers groups have been found to improve utilization, such as increasing office and preventive visits and decreasing emergency department and inpatient hospital admissions, while increasing survival rates.[1] Surveys suggest that while the vast majority of MA plans have some form of value-based contracts with network providers — ranging from patient-centered medical homes and bundled payments to shared savings/risk and global capitation — there is substantial opportunity to expand.[2] A voluntary demonstration under Section 1115A authority testing APMs in MA would further encourage providers to move away from volume-based payments towards risk-based contracts and help meet CMS' stated goals of moving more providers towards value based payment arrangements. We stand ready to work with CMS to develop the details of the demonstration model.

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[1] Mandal, Aloke K., Tagomori, Gene K., Felix, Randell V., Howell, Scott C. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. *American Journal of Managed Care* 23(2): e41-e49. February 2017.
[2] Deloitte. Unlocking the potential of value-based care in Medicare Advantage. 2016. Available online at: https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/value-based-care-in-medicare-advantage.html

We recommend that CMS consider the following guiding principles in designing a voluntary MA Advanced APM incentive demonstration program:

+ ***Basic structure.*** *One approach CMS could take under the demonstration would be to simply treat providers that (i) contract with MA plans, and (ii) meet requirements regarding EHR usage, quality and financial risk, as participating in Medicare Advanced APMs for QP determination purposes. Thus, for example, payments received from the MA plan, or patients served that were enrolled in the MA plan, would be taken into account in determining whether a provider meets the 25 percent minimum Medicare payment amount threshold or 20 percent minimum Medicare patient threshold, respectively. As with the existing Advance APM track, an APM incentive payment for these QPs would then be calculated based on the total amount of FFS Medicare payments they received. Providers participating in the demonstration would be exempt from MIPS, including both reporting requirements and any payment adjustments. This approach would therefore align with existing rules under MACRA that exempt QPs participating in Medicare Advanced APMs from MIPS. Under this approach, CMS should deem provider contracts with MA plans that include reporting under the Star Ratings System to meet the requirement of reporting on quality measures comparable to those used under MIPS, given the strong role that the Star Ratings program plays in MA. We also recommend that CMS permit flexibility in meeting EHR and financial risk requirements, such that alternative criteria may be applied to meet an equivalent standard, to continue to promote the type of private sector innovation observed to date.*

    + ***Infrastructure Support.*** *Another design element that CMS could consider would allow for advance payment to providers that do not currently qualify as QPs. This type of funding mechanism would create ready access to the capital providers require to invest in the infrastructure (e.g., IT, data analytic, patient engagement) necessary for transitioning to risk based payment arrangements. CMS could use the Advanced Payment ACO Model as a guide, which makes several types of upfront payments to participating providers as an advance on shared savings the organizations are expected to earn under the model.*

    + ***Budget-neutrality.*** *We understand the importance of developing a demonstration program that is designed to either reduce federal spending or remain budget neutral while enhancing quality. We recommend that CMS work with AHIP and the industry to consider ways to design the program and appropriately consider savings so this goal is achieved. For example:*

- *We believe potential savings need to be considered over the duration of the demonstration, rather than on a year-by-year basis, to recognize the time it can take to recognize the positive impacts that come from changes in practice patterns, and better care coordination and disease management. Under the MA-VBID model, for example, participating plans show budget neutrality over the five-year demonstration period of performance.*

- *CMS could consider reducing the potential costs of the program by making providers eligible for a range of bonus payments attributable to participation in an MA Advanced APM rather than a flat 5% bonus, with the largest payments reserved for providers in certain arrangements (e.g., capitation) that may be expected to achieve the greatest savings. Even if a provider receives a reduced amount, when it is combined with savings from avoiding MIPS reporting requirements, it could help providers adopt alternative payment arrangements.*

- *In considering potential sources of savings, CMS should consider the impact on the MA program, not just the FFS program. By encouraging MA providers to adopt alternative payment arrangements, the demonstration can reduce MA plan bids, thereby reducing costs to the government. As described above, value-based contracting in MA has been found to improve utilization – by increasing low-cost, high-value services like preventive visits and reducing high cost services like hospital readmissions – and increase survival rates, which over time will lower MA plans' cost of care. As such, increases in value based contracting arrangements should lead to lower MA costs – and therefore lower MA bids – than in the absence of the demonstration. Like the evaluation approach that CMS is using for the MA-VBID model, CMS could evaluate this demonstration for its impact on (a) outcomes, satisfaction, and out-of-pocket costs, (b) expenditures for participating health plans, and (c) plan bids over time to determine if the model results in savings.*

- *We also strongly encourage CMS to consider potential savings for the FFS program. Research demonstrates that where penetration is strongest, the MA program has had a "spillover effect" of decreases in Medicare FFS spending. Researchers have found that in counties with high baseline MA penetration rates, each 10-percentage point increase in MA penetration was associated with a decrease in FFS spending of $154 per patient*

annually.[3] Therefore, the adoption of alternative payment arrangements in MA by providers who might otherwise remain in MIPS could lead to changes in practices of care that will result in cost savings in the FFS program. These savings should also be factored into the demonstration program.

- ***Development of an Attestation Process**. CMS should develop a clinician-initiated attestation process that would be limited to collecting minimum, necessary data. Through this attestation process, clinicians would indicate the percent of payments, or patients, associated with qualifying MA payment arrangements. Inclusion of an attestation process would not only minimize administrative burdens for the agency, plans and providers, but would also help to ensure that proprietary or commercially sensitive information is adequately protected. Any payer-initiated attestation process would be voluntary.*
- ***Preservation of the Non-interference Clause.** §1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in the terms and conditions of an MA organization's contracts with providers. CMS cannot, under the statute, dictate pricing or contract terms between MA plans and their network providers. Moreover, specific information on risk sharing, capitation amounts, or shared savings arrangements between MA plans and their network providers is likely to be proprietary and commercially sensitive and disclosure of such contract-specific details would be anti-competitive. Therefore, while we support the goals of the demonstration to encourage providers to adopt APMs, it is critical that the demonstration remain voluntary, that it not involve the disclosure of competitively sensitive information, and that it otherwise be designed in a way to best preserve private sector negotiation and the principles of the non-interference clause.*

AHIP welcomes the opportunity to work with CMS to develop an MA Advanced APM incentive demonstration program guided by the principles described above. These principles are critical for ensuring that CMS' demonstration program effectively levels the playing field between FFS and MA, such that providers have equal incentives to take risk. Such a demonstration would recognize and reward the successful, innovative practices that MA plans and providers have already developed to better serve their patients, as well as ensure that the MA program continues its progress in delivering better care, improved health, and lower costs for Medicare beneficiaries.

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[3] Johnson, Garret, Figuero, Jose F., Zhou, Xiner, Orav, E. John, Jha, Ashish K. Recent growth in Medicare Advantage enrollment associated with decreased fee-for-service spending in certain US counties. *Health Affairs* 35(9):1707-1715. September 2016.

Physician-Focused Payment Models (PFPMs)

MACRA established the Physician-Focused Payment Technical Advisory Committee (PTAC) to assess additional APM proposals submitted by stakeholders and the CY 2017 final rule requires that PFPMs include Medicare as a payer.

In the proposed rule, CMS is seeking comments on broadening the definition of PFPM to include payment arrangements that involve Medicaid or the Children's Health Insurance Program (CHIP) as a payer even if Medicare is not included as a payer. CMS' rationale is that a broader definition might be more inclusive of potential PFPMs that could focus on areas not generally applicable to the Medicare population and could engage more stakeholders in designing PFPMs.

Comment:
We support CMS' proposal to broaden the definition of PFPMs and recommend that CMS consider including payment models submitted by commercial payers in the PFPM definition. Additionally, PTAC may wish to consider payment models for ancillary providers, such as long-term care, durable medical equipment, and laboratories. If CMS chooses to expand the definition of PFPMs and/or the types of other provider payment models that can be vetted by PTAC, CMS should ensure that committee members have the expertise necessary to properly evaluate and grade such models.

Thank you for the opportunity to provide these comments. We look forward to continuing to work with CMS in the national effort to transition to value-based health care.

Sincerely,

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