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AUGUST 17, 2017

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P
P.O. Box 8013
Baltimore, MD 21244-8013

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

Re: CMS-5522-P: Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

Better Medicare Alliance (BMA) is pleased to submit the following comments on the proposed rule updating the Quality Payment Program for calendar year 2018. BMA is a community of 90 ally organizations, who, like the nearly 19 million beneficiaries who have chosen Medicare Advantage, share a commitment to a strong Medicare Advantage option. We believe that Medicare Advantage is an important part of the Medicare program. It represents a public-private partnership that is addressing the needs of today's beneficiaries, while looking to technology and innovation to meet the needs of millions of future beneficiaries. Medicare Advantage payment system and flexibility is moving providers towards higher-value, higher-quality care, improving the health care experience for physicians and their patients.

From this vantage point, we write to express our support for the principles of the Medicare Access and CHIP Reauthorization Act (MACRA). We share the goal of moving providers away from Traditional Fee-For-Service (FFS) Medicare and towards value-based models of care delivery and reimbursement. Our comments below reflect our strong desire to see this work continue. We believe that the best way to quickly spread value-based models is to recognize Medicare Advantage's part in value-based contracting and align *all* Medicare payment models in this important effort.

Our major concern with MACRA implementation is the siloed nature of its focus on the FFS Medicare population. One-third of Medicare beneficiaries have their care insured through a Medicare Advantage plan. This is an 8% increase over last year, and enrollment is expected to rise to 41% of all Medicare beneficiaries by 2027.[1] More than nine in ten beneficiaries report high levels of satisfaction with the program.[2] The exclusion of this significant portion of the healthcare market, as part of the proposed MACRA rule, could complicate a smooth transition towards value-based care in delivery system reform.

We see three areas in need of attention:

- **Increase support for providers who are already complying with disparate systems of reimbursement and reporting:** Providers are already challenged by the byzantine systems of reporting required not just by Medicare, but Medicaid and commercial insurers as well. We are concerned about increasing administrative burdens - both the amount and inconsistency of reporting on providers. Physicians have one set of incentives and metrics for one payer, and a completely different set for another. MACRA creates additional inconsistencies within the Medicare program itself, only increasing the challenge for providers struggling to balance time between administrative and clinical responsibilities.

- **Increase support and recognition for the important work that providers are doing through value-based contracting in Medicare Advantage:** Within the value-based reimbursement structures established by Medicare Advantage plans, providers are meeting the challenge. As of June 2017, 65% of Humana's individual Medicare Advantage beneficiaries were enrolled in value-based relationships. Humana hopes to increase that rate to 75% this year. UnitedHealthcare currently has 2.4 million of its Medicare Advantage enrollees seeking care from a physician participating in a value-based program, and UnitedHealthcare paid $148 million in bonus payments to Medicare Advantage physicians in 2015 alone based on meeting quality measures. Medicare Advantage plans are also looking towards the future: Aetna has set a goal to have 75% of its medical spend in value-based contracts by 2020. In short, physician participation in value-based care through Medicare Advantage is robust, and many models may already be equivalent to an Advanced Alternative Payment Model (APM). Federal policy should, therefore, attempt to smooth the provider experience by recognizing value-based care wherever it exists.

- **Increase support and recognition for sophisticated systems that are using Medicare Advantage as their gateway to increasing assumption of risk:** More and more physicians, including large physician groups and health systems are partnering with Medicare Advantage plans to engage in sophisticated risk strategies. Many are forming unique, value-based contracts to align quality and cost incentives. Federal policy should encourage these arrangements as much as possible without bias, as they offer some of the highest alignment of care and quality incentives. That encouragement means allowing the Medicare Advantage and FFS Medicare programs to exist on a level playing field.

In order to advance the goals of value-based care, simplify the provider experience, and enhance beneficiary engagement and satisfaction, we recommend the following:

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1. Ensure physicians receive credit for qualifying, risk-based Medicare Advantage contracts in order to receive the five percent bonus payment for sufficient Advanced APM participation;
2. Simplify information requirements for value-based contracts in order to make Advanced APM determinations;
3. Modify Qualifying APM Participant determinations under the All-Payer Combination Option;
4. Clarify and provide early notification of a methodology for incorporating APM bonus payments and MIPS adjustments, including the exceptional performance add-on, into Medicare Advantage benchmark rates; and
5. Create alignment between Medicare Advantage and MACRA with regard to quality measures and financial risk standards.

A more detailed explanation of our comments follows.

1. Ensure physicians receive credit for qualifying, risk-based Medicare Advantage contracts in order to receive the five percent bonus payment for sufficient Advanced APM participation:

MACRA aims to move Medicare payments toward value and should encourage this move across all payment types. While we recognize MACRA's focus on transitioning FFS Medicare payments to value-based care, Medicare Advantage is advancing the movement towards value. Medicare Advantage plans are partnering with clinicians in risk-based arrangements that coordinate care and improve outcomes for Medicare beneficiaries. In fact, CMS has acknowledged the role of Medicare Advantage plans in driving the health care system toward value-based care, stating, "We recognize that Medicare Advantage contracts can include financial risk as well as quality performance standards, certified electronic health record technology (CEHRT), and other health IT requirements that support high-value care."[3]

As Medicare Advantage grows, clinicians and health plans are engaging in innovative partnerships to deliver higher-value and higher-quality care. In fact, not only are providers gravitating towards sub-capitated Medicare Advantage payment arrangements as a more effective way to deliver care, many providers are deciding to start their own Medicare Advantage plans. In 2016, provider-sponsored parent organizations represented nearly 60% of the new Medicare Advantage organizations entering the program.[4]

CMS must foster consistency across federal programs in this drive toward value-based payments, creating a level playing field for all Medicare value-based payment arrangements. Providers who are engaged in any type of qualifying, risk-based contract under Medicare should be rewarded under the Quality Payment Program. CMS should encourage value-based payments under federal programs by rewarding physicians who enter into risk-based, value-based contracts with Medicare Advantage plans.

Unfortunately, by focusing solely on FFS Medicare payments in the first two performance years, CMS fails to recognize and support the important work in which providers are engaging via risk-based Medicare Advantage contracts. In addition, by rewarding providers with a five percent payment bonus only for risk-based payments they receive under original Medicare, CMS policy potentially undercuts the Medicare Advantage program in the long term, driving clinicians away from coverage options that provide beneficiaries with coordinated care.

Therefore, we urge CMS to allow clinicians' contracts with Medicare Advantage plans that meet risk, quality, and certified electronic health record technology (CEHRT) requirements to be considered Advanced APMs, allowing clinicians to use qualified Medicare Advantage payment arrangements to meet the threshold for sufficient participation to qualify for the five percent bonus payment and exclusion from MIPS. We further urge CMS to make this change as soon as practicable and before the all-payer model becomes available in the 2021 payment year.

In implementing this change, we encourage CMS to explore flexibilities in statute or demonstration opportunities to support Medicare Advantage clinicians and health plans engaging in value-based arrangements. For example, we believe CMS has the statutory authority to permit eligible professionals to become Qualified Advanced APM Participants using the beneficiary count method outlined in section 1833(z)(2)(D) of the Social Security Act. As an alternative, CMS could use its authority under section 1115A of the Social Security Act to design a demonstration program that compares the cost and quality of care delivered in risk-based contracts under Medicare Advantage to the cost and quality of care delivered in traditional Medicare.

2. Simplify information requests for value-based contract requirements in order to make Advanced APM determinations:

In developing a pathway for clinicians to qualify for the Advanced APM five percent bonus payment by including qualifying, risk-based Medicare Advantage contracts as Advanced APMs, we urge CMS to simplify information required for determining whether Medicare Advantage payment arrangements with clinicians qualify as Advanced APMs. We acknowledge that making this kind of determination may require some level of transparency about the contract details between provider and plan. At the same time, we believe that the documentation requirements CMS has outlined under the Other Payer Advanced APM model are overly broad and should be modified to require only the information essential to ensure the protection of proprietary information.

CMS proposes that either payers or eligible clinicians may request a CMS determination of whether certain arrangements qualify as Other Payer Advanced APMs. Regardless of

whether the request is initiated by a payer or an eligible clinician, CMS proposes to require submission of the following information for each other payer arrangement:

- Arrangement name;
- Brief description of the nature of the arrangement;
- Term of the arrangement (anticipated start and end dates);
- Participant eligibility criteria (payer-initiated request only);
- Locations (nationwide, state, or county) where this other payer arrangement will be available;
- Evidence that the CEHRT criterion is satisfied;
- Evidence that the quality measure criterion is satisfied, including an outcome measure;
- Evidence that the financial risk criterion is satisfied; and
- Other documentation as may be necessary for CMS to determine that the other payer arrangement is an Other Payer Advanced APM.

We are concerned that these requirements, and the last requirement, in particular, are overly broad and may require disclosure of proprietary contracting information that we do not believe CMS has the authority to collect. Instead, in the short-term and for the Other Payer Advanced APM standard, we urge CMS to develop an attestation process that reduces or eliminates the disclosure of proprietary, value-based contracting information, ensures the confidentiality of this information with government entities, and prevents public disclosure. Under this attestation process, CMS should request only the information necessary to determine whether the payment arrangement meets the Advanced APM standard and to conduct any necessary audits. In addition, we urge CMS to maintain the protections that exist today with regard to the confidentiality of proprietary or sensitive contract information. In particular, we request that such information be protected from Freedom of Information Act (FOIA) requests or redacted if such information is made publicly available.

3. Modify Qualifying APM Participant determinations under the All-Payer Combination Option:

We appreciate the details CMS provided in the proposed rule regarding implementation of the All-Payer Combination Option created by MACRA. This option allows eligible clinicians to become qualifying participants by combining their all-payer revenue (including Medicare Advantage) with their Medicare Part B risk-based payments to qualify as an Advanced APM for the 2021 payment year.

However, we have concerns with CMS's proposal to make qualifying participant determinations under this option at the individual clinician level, rather than at the physician group or APM Entity level, as is the case for Medicare APMs. Risk assumption at the individual physician level is neither practical nor advisable. As clinicians increase their participation in value-based payment arrangements, they are increasingly likely to become

part of a larger entity or group that combines financial reporting, revenue, and risk for all clinicians in the group. These larger groups are able to achieve economies of scale in order to meet the numerous reporting requirements imposed on them by value-based arrangements and combine resources to provide the kinds of care coordination resources that foster clinicians' and patients' success under such arrangements.

Therefore, we encourage CMS to make the qualifying participant determination at the legal entity level and remove the burden placed on individual clinicians to report their individual revenue in order to qualify under the All-Payer Combination Option.

4. Clarify and provide early notification of a methodology for incorporating APM bonus payments and MIPS adjustments, including the exceptional performance add-on, into Medicare Advantage benchmark rates:

The statutory formula for determining Medicare Advantage county benchmark rates explicitly directs CMS to exclude certain FFS Medicare expenditures, such as indirect medical education expenditures, from that calculation. Because MACRA did not exclude APM incentive payments and MIPS adjustments, including the exceptional performance add-on payment, from calculation of the county benchmark rates, CMS is required to incorporate these expenditures into the benchmarks. We urge CMS to clarify its statutory requirement and its intent to incorporate these MACRA payments into Medicare Advantage plan benchmark rates.

In addition, CMS previously indicated it will address the impact of MACRA payments on Medicare Advantage benchmark rates in the 2019 Advance Notice and Rate Announcement. To avoid uncertainty, we urge CMS to address the incorporation of MACRA payments into the benchmark rates in the final MACRA rule, rather than waiting until the calendar year 2019 rate notice process

5. Create alignment between Medicare Advantage and MACRA with regard to quality measures and financial risk standards:

We urge CMS to recognize the role Medicare Advantage plans play in advancing value-based care by removing obstacles that keep clinicians from accepting risk under value-based arrangements. Clinician participation in alternative payment models is significantly diminished when they must manage different, and sometimes conflicting, requirements from different payers regarding risk standards, quality metrics, feedback reports, payment models, benchmarks, attribution, and more. Further, managing multiple APM contract elements can reduce clinicians' ability to improve quality and reduce costs, and so is counterproductive to the goals of a value-based arrangement.

For example, we urge CMS to fully align the nominal risk amount standards for Medicare

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Advanced APMs and Other Payer Advanced APMs. CMS proposed that under the All Payer Combination Option, determination of Advanced APM status for Other Payers will be based on a three-part test:

1. Marginal risk of at least 30%;
2. Minimum loss rate of no more than 4%; and
3. Total risk of at least 3% of the expected expenditures for which the APM Entity is responsible, OR a revenue-based nominal amount standard of 8%.

In order to lift the burden these differing standards place on providers, which may reduce their participation in the very models CMS is working to encourage them to join, we urge CMS to fully align the nominal financial risk standards for all Advanced APMs, regardless of payer.

In addition, there are substantial opportunities to align quality measures and standards between MACRA and Medicare Advantage. Payments to Medicare Advantage plans are already tied to quality through the Star Rating system. Using the Star Rating System, CMS and Medicare Advantage plans have worked to increase plan quality and beneficiary enrollment in higher-rated plans. Between 2013 and 2017, the average rating for Medicare Advantage plans offering Part D coverage (MA-PD) increased from 3.71 stars (out of 5) to 4.00 stars.[5] In addition, enrollment in plans with at least four stars more than doubled between 2012 and 2017.[6] This enrollment increase in high-quality plans is occurring both because Medicare Advantage plans are investing in quality improvement efforts to improve their Star Ratings and because beneficiaries are increasingly enrolling in higher-rated plans. The Medicare Advantage Star Rating System is clearly working, improving plan quality and performance to improve beneficiary outcomes.

However, the Quality Payment Program is not aligned with the Star Rating System. These disparate payer measurement systems increase the burden on providers and lead to fewer meaningful performance outcomes. We encourage CMS to align MACRA with other quality measurement systems, to reduce the administrative burden, prevent unnecessary duplication, focus on meaningful, actionable measures, and reduce the excessive information burden that falls on providers to qualify for, and engage in MACRA, Medicare Advantage, or other important, innovative programs.

Conclusion

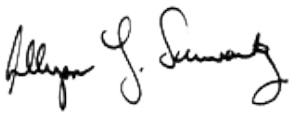
Medicare Advantage is a leader in driving innovation in care delivery and payment arrangements, and is contributing significantly to a more patient-centered, high-value, high-quality experience for Medicare beneficiaries. BMA and our ally organizations appreciate the payment mechanism and benefit flexibility that Medicare Advantage plans have been afforded to establish this environment. We are committed to working with CMS and

Congress to advance the best care for beneficiaries in Medicare Advantage. We appreciate your consideration of our comments on this proposed rule, which are designed to create a level playing field for Medicare Advantage plans and providers and ensure beneficiary access to the quality coverage and care offered through the Medicare Advantage program.

We share the Administration's commitment to ensuring Medicare Advantage is flexible, innovative, and efficient. We appreciate your experience and interest in looking for ways to move forward with new ideas, and to identify and tackle obstacles to success. We look forward to working with you and your staff to ensure Medicare Advantage is a strong, stable, sustainable, and cost effective option for current and future beneficiaries.

We urge CMS to find a path forward to implement the changes recommended above. We appreciate the opportunity to submit these comments and welcome further discussion.

Sincerely,



Allyson Y. Schwartz
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[1] http://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/
[2] https://www.hlc.org/news/new-poll-shows-high-satisfaction-rates-for-medicare-advantage/
[3] https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm p. 1787
[4] http://avalere.com/expertise/managed-care/insights/nearly-60-percent-of-new-medicare-advantage-plans-are-sponsored-by-healthca
[5] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-12.html
[6] http://files.kff.org/attachment/issue-brief-medicare-advantage-2016-data-spotlight-overview-of-plan-changes and http://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/