

May 31, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave, S.W.
Washington, DC 20201

Dear Administrator Verma:

The undersigned organizations represent the leaders in the value-driven agenda occurring in the U.S. healthcare sector. We appreciate the Centers for Medicare & Medicaid Services (CMS) push toward a new system in which quality and cost are valued over volume of services provided. The Medicare Advantage (MA) program has been a key component in those efforts and inspired many innovations in care that benefit patients and the Medicare program. With the onset of new payment models such as Alternative Payment Models (APMs), we want to ensure that MA continues to play a pivotal role in the transformation of patient care in this country.

Background

The Medicare Access and CHIP Reauthorization (MACRA) became law over two years ago with overwhelming bipartisan support in both chambers of Congress. Members of both parties agreed that the previous payment system was unsustainable and presented numerous barriers to needed improvements in patient care and delivery system reform. The MACRA law encouraged more seamless and coordinated health care delivery by altering payment incentives to promote patient health, higher quality, and better patient outcomes and experience of care. A key pathway under the new Quality Payment Program (QPP) is that physician and other health professionals have the opportunity to engage in the Advanced APM program where they shift all or part of their Medicare payment to an APM.

Under QPP, eligible professionals who meet or exceed minimum *revenue* thresholds coming from Advanced APMs or *minimum numbers of Medicare beneficiaries* in Advanced APMs can receive a 5 percent bonus on covered professional services under the Medicare physician fee schedule from 2019 through 2024. However, for the 2019 and 2020 payment adjustment years, current regulations specify that only Medicare FFS revenue and patients can be counted in this test; “Other Payers,” including MA arrangements, do not come into the equation until the 2021 payment adjustment year. **We urge CMS to alter its regulations to allow clinicians’ contracts with MA plans that meet the risk, quality and certified electronic health information technology requirements to be included under the beneficiary count test for the 5 percent Advanced APM bonus in 2019 and 2020.**

Legal Reasoning

While we agree with CMS that the underlying statutory language does not support the inclusion of revenue associated with an MA contract as part of the revenue thresholds test in 2019 and 2020 without the use of a waiver, we do believe CMS has the authority to permit eligible professionals to become qualifying participants within Advanced APMs under the beneficiary count alternative under section 1833(z)(2)(D) of the Social Security Act:

The Secretary may base the determination of whether an eligible professional is a qualifying APM participant under this subsection and the determination of whether an eligible professional is a partial qualifying APM participant under section 1848(q)(1)(C)(iii) by using counts of patients in lieu of using payments and using the same or similar percentage criteria (as specified in this subsection and such section, respectively), as the Secretary determines appropriate.

It is important to note that the statute shown above does not include any language that requires CMS to consider only Medicare FFS patients. It refers in general terms to "counts of patients." This is an important distinction from the language of the statute in other provisions of section 1833(z) of the Act, for example the revenue test for 2019 and 2020, where use of the defined term covered professional services means Medicare FFS Part B payments that are made under the Medicare physician fee schedule. Had Congress intended to tie the agency's hands under the patient count methodology to restrict countable patients to FFS Medicare beneficiaries, it would have had to so specify. Since the statute does not include limiting language requiring CMS to only count FFS patients, then the agency has the latitude to interpret this provision to include MA enrollees in the patient count methodology beginning in 2019.

Section 1833(z)(2)(D) itself does not dictate specific years for the implementation of certain policies or create distinctions between payer types, but rather allows the Secretary to do as he deems "appropriate." This provides CMS flexibility in terms of how it structures the beneficiary count test. In fact, CMS has already used this authority to set the beneficiary count thresholds lower than the revenue test—CMS does not follow the 25, 50 and 75 percent thresholds required under the revenue test for the beneficiary count test whether for FFS or other payers in out years. Thus, CMS has the authority to allow MA contracts to be included in 2019 and beyond as part of the beneficiary count alternative.

Step-wise Beneficiary Count Test

CMS should be careful in constructing an alternative that adds MA beneficiaries into the 2019 and 2020 counts to ensure no unintended consequences arise. For those clinicians who have MA contracts, but do not yet have Advanced APM structures within those contracts, simply adding MA beneficiary counts will dilute the denominator with no commensurate addition to the numerator. This could cause those clinicians who would have passed under the existing policy to fail the new test. Thus, we suggest CMS augment its current staged test for determining passage of the threshold determinations to prevent the unintended consequence of helping those areas

with high MA penetration, while harming those areas with low penetration. We believe that CMS can test clinicians' satisfaction of the Medicare FFS revenue and beneficiary thresholds first, and if a clinician or group of clinicians pass then they do not need to proceed to the next steps of the test. If they do not pass, then CMS could proceed to test Medicare FFS and MA together for a second stage of the beneficiary count test.

Align Financial Risk Standards

In the QPP final rule, CMS established financial risk requirements that are different for Medicare than Other Payers. For example, according to the preamble, Other Payer arrangements are held to additional marginal risk and minimum loss requirements.¹ Furthermore, CMS did not finalize a parallel option for clinicians to rely on 8 percent of the APM entity's other payer revenues to meet the nominal risk requirement, but instead requested comments. While CMS may have initially thought this could be determined later, it would be important to ensure the required nominal risk amount is clarified for the purposes of MA if it is included as part of the calculation for payment in 2019.

Research on physician participation in new payment models has found that the need to manage multiple and conflicting requirements from different payers is a strong disincentive to broader participation in these models and can also reduce the ability of physicians to improve quality and reduce spending. Different goals, quality metrics, performance feedback reports, payment models, benchmarks, and attribution and risk adjustment methods increase the time and costs that practices must spend on administrative activities rather than in patient care. CMS itself has urged alignment of payment structures in the multi-payer models that it has created.

Consequently, we recommend that CMS establish the same financial risk requirements for all Advanced APMs regardless of payer in order to facilitate the development of multi-payer models.

Attestation Process

In order for CMS to conduct the second stage of this test, the agency will need some basic information about clinicians' contracts with MA plans. We urge CMS to develop a *simple* attestation process with only the necessary information to conduct calculations and audits if necessary to minimize burden on clinicians and the agency alike. The 2016 QPP rule outlined some necessary information, but did not provide details. We are concerned that overly burdensome requirements, including the possible requirement of plans having to verify the information, may create an insurmountable hurdle for clinicians making an accurate estimate of their MA beneficiary counts.

¹ We note, however, that the regulatory text appears to have an error as it refers to both 3 percent of expected expenditures in paragraph (3)(i) and 4 percent of expected expenditures in paragraph (3)(ii)(B). We believe the second reference should say 4 percent maximum minimum loss ratio to be consistent with the preamble.

Timing

We believe that CMS can implement this change for payment in 2019. CMS finalized three snap shots for qualifying APM participants (QP) determinations with the last snap shot being August 31, 2017 for 2019 payment. Because CMS will allow for 3 months' claims run-out, it notes that the last of these three QP determinations will take place on or around January 1 of the subsequent calendar year (i.e. January 2018). If CMS includes a policy change in its expected proposed QPP rule this spring and finalizes the provision by fall, QPs could then attest in the late fall before the January 2018 calculation.

Conclusion

More than 31 percent of Medicare beneficiaries are enrolled in a MA plan and with the popularity of the program, numbers are increasing. Yet, leading edge clinicians who take risk under APMs within these MA contracts will not get credit for their efforts until 2021. CMS should be encouraging participation in Advanced APMs not only within Medicare FFS, but also within MA to improve care for all Medicare beneficiaries. Our proposal would encourage broader participation in risk arrangements by clinicians from the start, creating synergies that will reinforce their population-based strategies and translate into higher quality and more efficient care within Medicare. Moreover, it will level the playing field between geographic areas with high MA penetration and those with low penetration, to ensure more uniform adoption of these types of models for Medicare beneficiaries. While we do not expect the inclusion of these contracts to amount to a significant increase in spending from a national expenditure perspective, this policy change will be critical for bringing clinicians in certain areas into Advanced APMs and will be key to their success.

If you have any questions, please feel free to contact any of the signers below. Danielle Lloyd, VP policy & advocacy for Premier at 202.879.8002 or Danielle_Lloyd@premierinc.com.

Premier healthcare alliance
American College of Surgeons
American Medical Association
American Medical Group Association
American Osteopathic Association
America's Essential Hospitals
Healthcare Leadership Council
Healthcare Transformation Task Force
Medical Group Management Association
National Association of ACOs

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