The Voice of Accountable Physician Groups

November 1, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via email to CMMI_NewDirection@cms.hhs.gov

Re: Centers for Medicare & Medicaid Services: Innovation Center New Direction

Dear Administrator Verma:

We appreciate the opportunity to comment on the future of the Center for Medicare & Medicaid Innovation (the Innovation Center). We view the Innovation Center as a critical tool to advancing the nation's health care delivery system. We are pleased to see that the Administration is taking a closer look at the Innovation Center's future as there is significant potential to build on the work that has already been done and to drive the nation's health care providers toward value-based care models.

CAPG represents nearly 300 medical groups and independent practice associations across 44 states, Washington, D.C., and Puerto Rico. CAPG members participate in value-based payment models across all of Medicare and have successfully operated under risk-based payment models for over two decades. Our members participate in numerous existing Innovation Center initiatives, including the Next Generation ACO program, the Bundled Payment for Care Improvement initiative (BPCI), and Comprehensive Primary Care Plus (CPC+).

In response to the request for information (RFI) on the future direction of the Innovation Center, CAPG is pleased to put forth two recommendations. Our recommended models are consistent with the guiding principles for the future of the Innovation Center and satisfy the focus areas outlined in the informal Request for Information (RFI).

To summarize:

- We call on CMS to adopt a better ACO model, the Third Option, which would provide a capitated payment model option in the Medicare ACO portfolio.
- We call on CMS to adopt an advanced APM demonstration project in Medicare Advantage (MA) that could create an additional avenue for physicians (primary care and specialists) to become advanced alternative payment model (APM) qualifying participants.

Additional details are provided below.

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I. Context for our Recommendations

For years, the nation's physicians and physician groups have engaged in experimentation with various levels of risk-bearing in traditional Medicare, including bundled payments, the Primary Care Medical Home, and Accountable Care Organizations. While these experiments have yielded quality improvement and modest cost savings, physician stakeholders, including CAPG, have routinely called on CMS and HHS to articulate the destination of delivery system reforms.

To CAPG and our members, the ultimate destination is clear: capitated payments to physician organizations, paired with robust pay-for-performance elements, and an engaged patient population. The success of this model is well-documented across the country with other payers.

For example, a recent study by the Integrated Healthcare Association (IHA) examined the health care quality and cost across the state of California. The study finds strong evidence that models like the two we propose, yield higher quality care and lower costs. Relevant findings include:

- Commercial HMO products generally outperform commercial PPO products on both clinical quality measures and risk-adjusted cost. Commercial HMOs, which typically rely on integrated networks, outperformed PPO products on five of six clinical quality measures while consistently providing less costly care, on average $4,245 per enrollee per year for commercial HMO versus $4,455 for commercial PPO (a difference of $210 per enrollee annually).[1]
- HMO product utilization of integrated care delivery networks, with more robust care coordination processes and capitated payment models is a leading explanation for the higher performance of HMO over PPO.[2]
- In California, where much of MA is provided in capitated arrangements with physician organizations, statewide averages for emergency department visits, all-cause readmissions, and inpatient bed days are all between 50 percent and 75 percent higher in fee-for-service than they are for Medicare Advantage (567 vs. 373 emergency department visits per thousand-member years; 18.4 percent vs. 11.2 percent readmissions; and 1,363 vs. 789 bed days per thousand member years).[3]

A recent study in the *American Journal of Managed Care* compared two physician organizations – one paid fee-for-service and one capitated – in MA. The capitated group had higher quality on several metrics (discussed below) but the authors also concluded that the capitated group created savings not

[1] Integrated Healthcare Association, Benchmarking California Health Care Quality and Cost Performance (2016), available at http://www.iha.org/sites/default/files/resources/issue-brief-cost-atlas-2016.pdf.
[2] Integrated Healthcare Association, Benchmarking California Health Care Quality and Cost Performance (2016), available at http://www.iha.org/sites/default/files/resources/issue-brief-cost-atlas-2016.pdf.
[3] Integrated Healthcare Association, Benchmarking California Health Care Quality and Cost Performance (2016), available at http://www.iha.org/sites/default/files/resources/issue-brief-cost-atlas-2016.pdf.

observed in the fee-for-service (FFS) group. Specifically, the capitated group reduced emergency department visits per 1,000 members. In this specific case, 154 fewer ED visits per 1,000 members yielded $100,915 in estimated savings, and 143 fewer inpatient admissions per 1,000 members saved $1,756,869.[4]

However, perhaps even more importantly, the advanced APM group had a six percent better survival rate and a 32.8 percent lower risk of dying as compared to the FFS group.[5] The capitated group reduced emergency department visits and inpatient hospital admissions by 11.2% and 11.9% respectively.[6] The reduction in ED visits results in savings of $100,915 and the reduction in inpatient admissions saved $1,756,869.[7]

The two models described below have the potential to spread these types of results across the country. In addition, these capitated delivery models provide systematic improvements necessary to care for the population of the future – a population that is living longer with multiple chronic conditions.

II. The Innovation Center should test the Third Option – an advanced and improved accountable care model that features capitated payment to physician organizations.

Based on our members' vast experience with Medicare ACOs and risk contracts outside of traditional Medicare, our Board members developed an improved ACO model, the Third Option. In brief, the Third Option seeks to address the flaws of existing ACO models built on FFS platforms. Our member companies came together to analyze existing ACO constructs and to recommend improvements to bring these models closer to successful risk contracts used in commercial arrangements. The resulting Third Option design is described in detail below.

a. Formation of clinically integrated organizations

Under our proposed Third Option, CMS would contract directly with clinically integrated organizations (CIOs). CIOs may be existing physician organizations or newly formed entities.

The CIO would be explicitly physician group centric. However, other providers could take ownership stakes, or could accept a measure of risk and accountability through affiliation agreements. This could include a broad spectrum of health care providers, including physicians, hospitals, nursing homes, home health organizations, and other entities wishing to be accountable for the delivery of care to a defined patient population across the continuum of care. The CIOs would feature team-based care, led by primary care physicians and supported by other providers operating at the top of their licenses (e.g., nurse practitioners, physicians' assistants, pharmacists, social workers).

To participate in this model, CIOs would have to meet certain requirements, similar to those required for existing Medicare ACO participants:

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[4] Mandal, et al. Value-Based Contracting Innovated Medicare Advantage Healthcare Delivery and Improved Survival, *American Journal of Managed Care* (2017).
[5] Mandal, et al., *Value-Based Contracting Innovated Medicare advantage Healthcare Delivery and Improved Survival*, Am. J. Manag. Care 2017:23(2).
[6] *Id.*
[7] *Id.*

- A formal legal structure that allows the organization to receive capitated payment and pay contracted or employed providers;
- Primary care professionals sufficient to care for the defined population;
- A minimum of 10,000 participating beneficiaries;
- Systems in place to identify and provide care for high risk and complex patients;
- The ability to stratify the population (identifying patients with multiple complex chronic conditions and to tailor care management programs to the patient population);
- Demonstrated experience in quality performance programs.

b. Active beneficiary enrollment

The Third Option would build on the attribution model currently used in Medicare ACO programs. For the first two years of the CIO's participation in the model, CMS would use the prospective attribution methodology currently used in the Next Gen program combined with an enrollment option that would allow beneficiaries to voluntarily enroll in the CIO. After the first two years, the CIO would migrate to an enrollment-only model, with the ultimate goal being full transition to enrollment. Beneficiaries who enroll would commit to receiving services in the CIO for one year. Experience has taught us that active, intentional enrollment by an engaged and informed beneficiary is vastly superior to passive attribution models used in traditional Medicare ACOs.

To facilitate beneficiary election of a CIO, quality and service information would be made available to the beneficiary. CIO-level information would be developed by stakeholders, including physicians, approved by CMS, and then disseminated by both CMS and the CIO to allow consumers to make fully informed choices about their care. Beneficiaries would be empowered with information regarding the quality, cost, and scope of services available under each of FFS, MA, and the CIO, including additional care management programs or benefits.

c. Benefits

The Third Option would cover the standard Medicare Part A and Part B benefits.[8] CIOs would have the option to work with a Medicare drug plan to offer Part D benefits, but CIOs would not be required to offer pharmacy benefits. If the CIO did not offer Part D benefits, such benefits would continue to exist alongside the Third Option.

d. Premium

In the Third Option, the Part B premium would be reduced for beneficiaries that select the Third Option for a year and actively select a primary care physician within the CIO. The percentage to be waived is to be determined with the aim of providing sufficient incentive for beneficiaries to select the CIO and providing sufficient funding for the program. This partial waiver of premium, coupled with the provisions relating to Medicare supplemental insurance below, should make the Third Option attractive to many seniors.

[8] A variation, or track, within the Third Option could also include a capitated payment for professional services only (Part B). This is a common arrangement used in the marketplace today and could serve as a pathway to engage additional physician groups and organizations in value-based care.

e. Beneficiary engagement

As with traditional Medicare, beneficiaries would be free to access services from any Medicare contracted physician. However, to incentivize beneficiaries to access in-network care as directed by their chosen primary care physician, services rendered by out of network providers would be subject to higher out of pocket costs. Prior authorization for certain high cost services would be required. The higher cost-sharing for use of services outside the CIO is designed to achieve the twin goals of allowing freedom of choice but incentivizing the efficiencies and higher quality that can be obtained by consistently accessing a highly organized, financially aligned, and electronically connected network of team-based providers. To encourage beneficiaries to seek high value care, including preventive services, beneficiaries would not need to pay a deductible and would have no copayments for preventive services. To provide beneficiaries with additional incentives to access in-network services, Medicare supplemental policies sold to CIO beneficiaries would be required to provide coverage for in-network services only. Beneficiaries would remain free to access services out of network, but would do so without the benefit of supplemental insurance coverage. This would likely necessitate the creation of an ACO-specific supplemental offering.

f. Payment to CIOs

CMS should establish capitation rates for CIOs in the same way it sets those rates for MA plans. The payment should be actuarially sound and use accurate risk adjustment. One capitated payment would cover the entire population of the CIO.

As with MA capitation rates, the capitated amount would be updated each year. The capitation amount would be published in advance to allow CIOs to decide whether to continue participation and to permit an orderly transfer for beneficiaries to other options if the CIO found that the proposed capitation was inadequate.

CMS would pre-pay this amount to the CIO each month in lieu of Medicare Part A and Part B FFS payments for those beneficiaries, thus creating the alignment and incentives to produce lower cost trend and higher quality than experienced in the past. The CIO would be responsible for the payment for all professional and hospital services, whether provided in-network or out-of-network.

The CIO will be free to use its capitated payments to invest in providing care to treat social determinants of health. CIOs will present plans to CMS as to what specific services the CIO proposes to offer. Patients will benefit from these enhanced benefits and the attention to their total health needs.

The Third Option guarantees savings to Medicare. The payment level for the capitated rate would be set at a rate of 98 percent of what FFS spending would have been for the population. Unlike a shared savings model, savings to the federal government are guaranteed.

g. Administration and Operations

Rather than building expensive health plan infrastructure and capacity, CMS would, at its expense, contract with one or more Affiliated Service Organizations (ASOs) to administer the eligibility and enrollment process, make capitated payments, receive encounter data from the CIOs, operate the quality and incentive bonus program, and conduct all other functions necessary to operate the Third Option. In particular, the ASO will be necessary to handle the complexities associated with

administering differential cost sharing for the out-of-network benefit. CMS may elect to contract with one or more national insurance carriers with the existing infrastructure and systems necessary to rapidly implement this program. The expectation is that the use of national health plans in this ASO, non-risk bearing capacity will result in lower cost for these services than currently experienced within MA. The ASO model will mimic the use of an ASO by self-insured employers in the commercial context.

h. Quality and efficiency measurement

The Third Option would use two layers of quality and efficiency reporting and performance evaluation. One would be an external, MA Stars rating or ACO-like quality reporting system. These measures would be publicly reported, would assess quality, efficiency, and patient satisfaction at the organization level, and would be used to make comparisons with MA and FFS Medicare. Quality measures would be developed, tested, and rolled out consistent with accepted practices. These measures would apply and be reported at the CIO level (not the individual provider level).

In addition, to ensure that CIOs have a strong business case for the delivery of high quality care, CIOs would be required to maintain a pay-for-excellence program to incent their downstream providers to deliver high quality care. The compensation payable to providers under these programs would be paid by the CIO from the capitation rates (CMS would not make a separate payment to the CIO's individual providers). Under this program, incentive compensation of as much as 15 percent of total provider compensation will be tied to high performance on quality measures, a model which has been demonstrated to successfully drive provider behavior.

CMS would develop quality floors for CIO participants. If the organization's performance fell below the floors, the organization would no longer be able to participate as a CIO. In the years following the MACRA advanced APM bonus years, CIOs should be eligible for an incentive program like the MA Five Star incentive program, where high performers are eligible for additional payments.

i. Additional Considerations

Additional considerations for CMS are similar to those in the current ACO program and Medicare Advantage, and include: Stark and anti-kickback waivers; compliance with state insurance law; and marketing requirements related to enrollment.

j. Conclusion

The time for the next iteration of the ACO program has come. Physician organizations have long called on CMS to articulate the destination for delivery system reform. The Third Option offers that destination and will be an attractive APM option for many sophisticated, risk-bearing organizations across the country. In addition, we note that there is bipartisan support for this concept in Congress.

III. The Innovation Center should adopt an advanced APM demonstration project in Medicare Advantage that could create an additional avenue for physicians (primary care and specialists) to qualify as advanced alternative payment model qualifying participants.

a. Background: the urgent need for additional advanced APMs

Under MACRA, certain qualifying models can become eligible for advanced APM status. The statute defines bonus-eligible advanced APMs to Innovation Center demonstration projects, MSSP, ACOs, and demonstrations required by federal law. In addition, advanced APMs must participate in a quality program comparable to MIPS; use certified electronic health records technology (CEHRT); and bear more than nominal financial risk or be a qualifying medical home.

To qualify for the five percent advanced APM bonus, APMs must have a certain threshold of their Part B revenue or patients in the advanced APM. For the first two years of MACRA implementation, that threshold has been spelled out to in include 25 percent of Part B payments or 20 percent of Part B patients. In later years, the Medicare Part B threshold increases to 50 percent and then 75 percent.[9]

Under current regulations and sub-regulatory guidance, only a handful of models qualify as advanced APMs. The majority of these models are Innovation Center demonstrations. The existing models, all built upon Part B, show promise, but have thus far exhibited mixed results and modest success. Currently, no MA arrangements count as advanced APMs and MA risk does not count toward an organization's Medicare risk threshold.

In its proposed rule earlier this year, CMS proposed excluding roughly 64 percent of clinicians from MIPS. These are mostly small groups and rural providers. This means, that many CAPG member companies and other large physician organizations will remain in MIPS, competing against each other. In addition, because of the budget neutrality provisions in MIPS, CMS itself indicates that the bonus pool will be limited – many clinicians will be either excluded or able to pass the low MIPS threshold for the 2017 performance year, and proposed for the 2018 performance year. Taken together with MACRA's zero percent update to the physician fee schedule in later years, this is a powerful incentive for groups to move from MIPS to the advanced alternative payment model track.

However, the limited number of models in Part B do not offer sufficiently attractive or numerous options for physician groups who want to get out of MIPS and into advanced APMs. CMS clearly needs to swiftly adopt new advanced alternative payment models to remedy this problem.

We believe that the fastest and most equitable way to do this is to create an advanced APM demonstration project for physician organizations participating in risk contracts in MA.

b. CMS has clear legal authority to create an MA APM demonstration project.

CMS has the legal authority to use Section 1115A of the Social Security Act to test new models with the potential to lower costs and maintain or improve quality of care offered to patients.[10] CMS should use this legal authority to design a demonstration project to compare the cost and quality of care delivered in risk contracts between MA plans and physician organizations to the cost and quality of care delivered in traditional Medicare.

[9] Beginning with the 2021 payment year, advanced APMs may count "all payer" revenue in addition to 25 percent of their Medicare Part B revenue to reach the thresholds to qualify as an advanced APM. We note that in all years of the MACRA APM bonus, CMS has proposed to require participation in Medicare Part B payment models.

[10] Memorandum from Akin Gump to CAPG re: CMS has legal authority to make incentive payments to participants in Medicare Advantage alternative payment models (April 7, 2017).

This MA APM option would then become a "qualifying model" under the MACRA statute by virtue of being an Innovation Center demonstration. Furthermore, once within the Innovation Center, CMS can use waiver authority to modify the existing Medicare Part B revenue test to include MA revenue, creating a modified revenue threshold that includes Medicare risk revenue from Part B and MA risk revenue. In addition, or in the alternative, CMS could use the patient count threshold without a waiver as the language for that category is broader and permits the inclusion of MA patients as currently written.[11]

As mentioned above, for the Innovation Center to test a model, models are to be expected to lower costs and improve or maintain the quality of care. An existing body of evidence, cited above, proves that risk contracting between plans and providers in MA satisfies both tests.

Second, there is compelling evidence that this demonstration will save money as compared to traditional Medicare. Research dating back to the 1990s has showed that as the penetration of managed care increases, traditional Medicare spending is reduced. Recent research has similarly shown that greater MA market penetration is associated with reduced costs in traditional Medicare and slowed growth in traditional Medicare spending.[12]

In addition, the Medicare Payment Advisory Committee (MedPAC) has published findings showing that enrollment-weighted bids in MA averaged 94 percent of FFS spending in 2016. MedPAC estimates that HMOs bid an average of 90 percent of FFS spending. These numbers suggest that HMOs can provide the same services for less than FFS in the areas where they bid.[13]

Creating incentives for physicians to participate in risk-bearing relationships in MA (where today there may be barriers to doing so across the country) will be one step forward in accelerating the spread of MA risk contracts. We believe that this policy will help continue to rapid growth of MA across the country, thereby controlling costs and lowering FFS spend.

c. CMS should adopt a model design that facilitates physician group and independent practice association participation.

Below is a detailed description of the model we are suggesting. We note that this model builds off, but modifies, what CMS has proposed for the all-payer calculation that is required to begin in the 2019 payment year. We urge CMS to adopt this demonstration project in 2018. Not only will that benefit

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[11] Memorandum from Akin Gump to CAPG re: CMS has legal authority to make incentive payments to participants in Medicare Advantage alternative payment models (April 7, 2017).

[12] M. Chernew, et al., Managed care and medical expenditures of Medicare beneficiaries, Journal of Health Economics (2008), available at http://www.sciencedirect.com/science/article/pii/S016762960800101X?via%3Dihub; C. Afendulis et al., The Effect of Medicare Advantage on Hospital Admissions and Mortality, National Bureau of Economic Research (2013), available at http://www.nber.org/papers/w19101; K. Baicker, et al., Medicare Payments and System-Level Health-Care Use: The Spillover Effects of Medicare Managed Care, American Journal of Health Economics (2015), available at http://www.mitpressjournals.org/doi/abs/10.1162/AJHE_a_00024#.V7Q3MmCEB1R; Johnson G., et al., Recent Growth in Medicare Advantage Enrollment Associated with Decreased Fee-for-Service Spending in Certain US Counties, Health Affairs (2016), available at http://content.healthaffairs.org/content/35/9/1707.abstract.

[13] Medicare Payment Advisory Commission, Data Book June 2016, available at http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-9-medicare-advantage.pdf?sfvrsn=0 (accessed Aug. 4, 2017).

clinicians by allowing them to participate in the advanced APM track of MACRA should they desire to do so, but it will give the agency crucial experience with a significant component of the advanced APM all-payer option prior to the nationwide rollout of that option.

First, we would use the eligible clinician submission option to allow medical groups and IPAs to submit MA risk contract information to CMS for consideration as an advanced APM. Leveraging off of the organized administrative systems of the groups and IPAs will bring efficiency and accuracy to the program.

The medical group or IPA would submit a summary of relevant contract terms[14] from the health plan-group contract to CMS for approval as an advanced APM qualifying model. The medical group or IPA would also submit a list of clinicians participating in the risk contract, including the TIN-NPI combination for each clinician.[15] The medical group or IPA will attest to its MA revenue and MA patient count information. CMS will calculate the traditional Medicare information for the medical group or affiliated IPA doctors, just as it currently does for traditional Medicare advanced APM participants.

CMS will use the reported TIN-NPI combinations to identify the individual clinicians and tally the Part B revenue for participating clinicians for purposes of calculating the amount of the bonus CMS will pay. This step is identical to the process CMS uses for advanced APMs under current regulation.

Note, unlike the CMS proposal for implementing the all-payer thresholds, we propose that CMS calculate the risk and patient count threshold performance at the group or IPA level, not at the individual clinician level. Once that risk level is achieved by the APM entity, CMS should use the traditional Medicare revenue information to pay the bonus to the participating clinicians' Medicare Part B billing TINs. This is consistent with current CMS practice in traditional Medicare.

We believe that assessing risk at the individual clinician level is unworkable. The key reason is that risk contracts in MA tend to exist between the group or IPA (APM entity) and the plan and not between individual clinicians and the health plan. Instead, individual clinicians may contract for a subcapitated payment, salary, or other form of compensation from the physician group. We believe that a standard that requires individual clinicians to report all of their income from different sources and determine risk at the individual level will be unworkable, burdensome, and will not necessarily give CMS the information it needs about the underlying contract between the MA plan and the group. Furthermore, the individual clinician assessment does not align to what is required in traditional Medicare, where, in general, risk is assessed at the group level. Creating a different standard in MA adds unnecessary complexity to the implementation of the QPP.

Below we provide additional detail on how the model would work. Because we see key differences in how medical groups and IPAs would participate, we have separated out detailed processes for each organization type.

Detailed Process between CMS and Staff/employed model Medical Group

[14] Relevant contract terms should be limited to those that have a direct bearing on MACRA APM status: quality, CEHRT and risk. CMS should minimize the required disclosures to reduce burden on physicians and groups and streamline data collection.

[15] In the case of an IPA, the clinician list would be limited to those with "meaningful participation" in the IPA's MA risk contract. This concept is described in greater detail below.

1. Physician group submits a summary of the relevant terms of its MA risk contracts to CMS for review. These terms align to the MACRA definition of an advanced APM (quality measurement, CEHRT, and more than nominal risk). The group will also need to submit a list of clinicians participating under the arrangement. [Appendix A]. The physician group will need to do this for each MA contract with multiple MA plans that may qualify as an advanced APM.

    a. Name of arrangement

    b. Geography covered

    c. Term of arrangement (contract start and end dates)

    d. Describe accountability for 5 star quality measures[16]

    e. Describe requirements that more than 50 percent of clinicians use certified electronic health records technology (CEHRT).

    f. Describe "more than nominal risk" provision (including capitation) for the physician group.

    g. List individual clinicians participating in the arrangement (include TIN-NPI combination for each clinician).

2. CMS reviews the submission and determines whether the contract between the health plan and the group meets the MACRA criteria as an advanced APM. If so, CMS lists the name of the arrangement as an advanced APM on the CMS website.

3. Physician group submits its total MA revenue and MA patient count information to CMS to support the calculation of the MA revenue and patient count thresholds [Appendix B].

4. Physician group must attest to or certify the accuracy of all information submitted to CMS. CMS retains the right to audit this information.

5. If the physician group meets one of the two thresholds (revenue or patient count) based on a threshold that combines its reported MA information plus CMS-calculated traditional Medicare information, CMS will pay a bonus to the Part B billing TIN equal to five percent of the **traditional Medicare** revenue.

Detailed Process between CMS and IPAs

1. CAPG proposes that IPAs function like medical groups for purposes of the MA APM.

2. The IPA submits a summary of the relevant terms of its MA risk contracts to CMS for review. These terms align to the MACRA definition of an advanced APM (quality measurement, CEHRT, and more than nominal risk). The IPA will need to submit a list of clinicians participating under

[16] CMS should deem the 5 star ratings program quality measurement to be equivalent to what is required under MIPS, sufficient to meet the MACRA requirements for quality.

the arrangement [Appendix A].[17] The IPA will need to do this for each MA contract with multiple MA plans that may qualify as an advanced APM.

   a. Name of arrangement
   b. Geography covered
   c. Term of arrangement (contract start and end dates)
   d. Describe accountability for quality measures.
   e. Describe contractual requirement that more than 50 percent of clinicians use certified electronic health records technology (CEHRT).
   f. Describe "more than nominal risk" provision (including capitation) for the physician group.
   g. List individual clinicians with "meaningful participation"[18] in the arrangement (include TIN-NPI combination for each clinician).

3. CMS reviews the submission and determines whether the contract meets the MACRA criteria as an advanced APM. If so, CMS lists the name of the arrangement as an advanced APM on the CMS website.
4. The IPA submits its total MA revenue and MA patient count information to CMS to support the calculation for the revenue and patient count thresholds for its MA population. [Appendix B].
5. IPA must attest to the accuracy of all information it submits to CMS regarding the IPA's MA contracts and revenue. CMS retains the right to audit for accuracy.
6. CMS will calculate the traditional Medicare revenue and patient count information for the clinicians listed in step 2 above.
7. CMS will determine if the IPA meets one of the two thresholds (revenue or patient count) based on a threshold that combines the IPA's reported MA information plus CMS-calculated traditional Medicare information. Again, the revenue and patient count tests would be modified to reflect a combined MA and traditional Medicare revenue/patient count (rather than only Part B as is current practice). IPAs, like medical groups, should remain free to participate in both a Part B APM and an MA APM.

[17] In IPA relationships, some clinicians are "non-exclusive" meaning that they participate with multiple IPAs. We believe that defining "meaningful participation" in an IPA will address the participation of these clinicians. However, there may be instances where a clinician has less than meaningful participation with multiple IPAs and his or her total practice revenue exceeds the thresholds. As the agency has done for traditional Medicare participants in multiple APMs, CMS should design an "exception" for these clinicians as well.

[18] For purposes of IPA arrangements, we recommend that CMS develop a volume test to ensure that clinicians participating in the IPA and benefitting from the bonus payment are strongly tied into a coordinated care model. We suggest that CMS may want to mirror the low-volume threshold set out for MIPS: $90,000 or less in Part C payments or 200 or fewer Part C patients with the IPA.

8. If the IPA meets the patient count or revenue threshold, CMS will calculate the bonus payment amount based on information CMS collects related to Part B payments to clinicians on the IPA's list.

9. Bonuses will be paid to the Medicare Part B billing TIN for the participating clinician, just as is done in traditional Medicare advanced APMs today.

10. The IPA will notify its clinicians that it is submitting their names on a list that may allow them to qualify for a bonus and escape MIPS. The IPA will collect acknowledgements in writing from its contracted clinicians that the IPA is submitting this information on the clinician's behalf. [Appendix C and D].

Today, CMS uses only Part B revenue to calculate the risk and patient count thresholds. We are proposing, for both IPAs and medical groups, a combined Medicare threshold that would aggregate Part B and Part C revenue or patient counts for a single threshold calculation. Our intent is that physicians with MA risk will qualify. Those that already qualify by having a Medicare ACO or other qualified entity using their Part B revenue should have the option to participate in both the Part B qualifying model and the MA APM model described above. This would enable physicians and physician groups to combine their Medicare risk revenue to meet the escalating risk thresholds in later years (50 percent and 75 percent). As an example, a group participating as a Next Gen ACO could also qualify as an MA APM and could use both risk arrangements to meet the new Medicare threshold.

d. Additional considerations.

A few additional considerations to highlight for CMS. First, any process CMS adopts for the MA APM demonstration should minimize reporting burdens on physicians and physician groups. Self-reporting, attestation, and auditing should be sufficient to protect the trust funds from fraud and abuse, as is the practice in current Medicare models.

Second, the model we outlined above would apply a five percent bonus to the clinicians' part B revenue only, not the Part C revenue. In prior comments, CAPG has outlined a recommended solution to apply a bonus to MA revenue to encourage the adoption of risk contracting in MA. We are hopeful that in forthcoming rulemaking and guidance on the MA program, CMS will continue to explore how it can encourage the proliferation of capitated coordinated care downstream from health plans in MA.

Third, the Innovation Center may need to deploy additional waiver authority to address Stark Law concerns, as it has done with the traditional Medicare models.

Finally, we note that the timing of this demonstration is critical. We call on CMS to implement the above demonstration beginning in December 2017, just as it has proposed for the creation of virtual groups. While we know that CMS and the PTAC are working to bring new models online, we fear that the pace will not be fast enough to allow our risk-bearing clinicians to access the advanced APM pathway and will leave these sophisticated players in MIPS. Rapid introduction of MA APM options will facilitate a faster transition to value across the country and will provide clinicians with valuable new options to advance their risk-bearing capabilities.

Again, please do not hesitate to contact me or Mara McDermott, CAPG's Vice President of Federal Affairs (mmcdermott@capg.org) with any questions.

Sincerely,

Donald H. Crane
President and CEO
CAPG

APPENDIX A:

Submission Template for Approval of Contract between MA Plan and Physician Organization

Name of submitting physician group or IPA:

Name of Medicare Advantage Alternative Payment Model:

Counties or service areas covered by this arrangement:

Term of the arrangement (start date and end date):

Describe how the physician organization is accountable for quality measures (attach a list of quality measures used by the organization):

Describe the contract's requirement that participating clinicians use certified electronic health records technology:

Describe how the physician organization takes risk under the contract:

Other details about care coordination under the contract that demonstrate qualification as an advanced APM (optional):

Attach a list of clinicians participating in the arrangement. Please include the NPI for each clinician listed:

APPENDIX B

Submission Template for Risk Threshold Determination

MACRA requires that APM entities meet certain risk thresholds to qualify as advanced alternative payment models eligible for the five percent bonus. While CMS has access to the traditional Medicare revenue information, you will need to disclose your MA contracting information.

Physician groups and IPAs will report the total MA revenue paid to the group or IPA. This will be broken down as follows (aggregated across all contracts submitted to CMS and approved as advanced APMs).

Category	Amount
A. Physician organization's total MA revenue	
B. Physician organization revenue paid to physician organization through CMS-approved MA advanced APM contracts	
C. Physician organization's total count of MA beneficiaries	
D. Physician organization's count of MA beneficiaries through CMS-approved advanced MA APM contracts	

APPENDIX C

Template Letter from IPA to Eligible Clinicians

To: Physicians participating in approved MA APM contract model

From: Independent Practice Association

Re: Notice of Ability to Qualify for MACRA Advanced Alternative Payment Model Bonus Payments

Dear Clinician,

We have submitted our Medicare Advantage (MA) contracts for consideration as advanced alternative payment models (APMs) under the Medicare Access and CHIP Reauthorization Act (MACRA). As part of this submission, we have listed you as a clinician that participates in this model.

As you may know, MACRA created a new payment system for traditional Medicare. Clinicians may participate in either the Merit-Based Incentive Payment System (MIPS) or in an advanced APM. Clinicians in MIPS have an increasing percent of their fee-for-service payments tied to their performance. Clinicians in APMs are eligible for a bonus payment applied to their Part B revenue, provided that they meet certain criteria.

Our IPA has submitted our MA risk contracts to qualify as an advanced APM. If our IPA qualifies, you will be eligible for a bonus payment and will be exempt from MIPS.

If you have questions, please contact [contact person].

Sincerely,

IPA Executive

Appendix D

Acknowledgment from IPA Clinician

[DATE]

[Address to IPA]

Dear IPA Executive,

I, [insert clinician name], hereby acknowledge that I have received information and instruction from [insert IPA name] regarding by participation in the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program.

The information I have received indicates that I will be listed as a participating provider in the IPA's Medicare Advantage Alternative Payment Model contract by virtue of my meaningful participation with the IPA in a Medicare Advantage contract.

By signing below, I am indicating my consent to be included on the IPA's submission. I recognize that this may qualify me to be exempt from the Merit-Based Incentive Payment System (MIPS) and may qualify me for a five percent incentive payment in traditional Medicare.

_____ _____

Signature of IPA Clinician