



January 16, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: Medicare Program: Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare fee-for-service, the Medicare Prescription Drug Benefit Programs, and the PACE Program [CMS-4182-P]

Dear Administrator Verma:

We appreciate the opportunity to comment on the Medicare Program: Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare fee-for-service, the Medicare Prescription Drug Benefit Programs, and the PACE Program Proposed Rule [proposed rule].

America's Physician Groups (APG, formerly CAPG) represents nearly 300 medical groups and independent practice associations across 44 states, Washington, DC and Puerto Rico. Our members are paid percent-of-premium capitation by health plans in Medicare Advantage (MA) and some are globally capitated for both professional and hospital services. This population-based payment method avoids the fee-for-service model's deleterious incentives for volume. Instead, this model aligns incentives for physicians to keep individual beneficiaries healthy as they improve the health of entire populations.

Our members' value-based payment arrangements create incentives for: (1) a team-based approach that emphasizes primary care; (2) physician organizations to provide the right care at the right time in the most appropriate setting; and (3) a care team that addresses the patient's total care needs, including mental health, behavioral health, and the home environment.

We know that MA provides better quality care for seniors. The December issue of *Health Services Research* included an analysis of MA contracts in three states: California, New York, and Florida.¹ The study looks at performance on 16 clinical quality measures and six patient experience measures for 9.9 million beneficiaries. The study found that MA outperformed FFS

¹ Timbie, J.W., et al, Medicare Advantage and Fee-for-Service Performance on Clinical Quality and Patient Experience Measures: Comparisons from Three Large States, *Health Services Research* (2017) available at <http://www.hsr.org/hsr/abstract.jsp?aid=52656627620> (accessed January 11, 2018).

on all 16 of the clinical quality measures and on five of six patient experience measures.² Notably, MA-HMO plans outperformed MA-PPO plans on 14 of 16 clinical quality measures.³

Furthermore, we know that the way in which physicians are paid downstream from the MA plan has an impact on the quality of care that patients receive. Our members have long demonstrated that value-based arrangements downstream, including capitation, offer higher quality than fee-for-service payments downstream. Illustratively, a recent study in the *American Journal of Managed Care* compared quality between two physician groups: one where an MA plan paid fee-for-service downstream to physicians and one where the MA plan paid capitation to the physician group (an advanced alternative payment model or APM). The advanced APM group's patients had a six percent better survival rate than the FFS group. Further, the Advanced APM group achieved 11 percent lower emergency department utilization and nearly 12 percent lower inpatient utilization as compared to the FFS group.⁴

Given the evidence of superior quality in MA, we know that growing the program and encouraging innovation by plans and providers in MA is the right policy direction. We are encouraged that many of the policies in the proposed rule can further incentivize the growth and development of MA. Our specific comments on those proposals are set out below.

I. APG supports flexibility in the MA uniformity requirements.

In the rule, the Centers for Medicare & Medicaid Services (CMS) proposes permitting MA organizations to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees that meet specific medical criteria. This flexibility is available provided that all enrollees who meet the specific criteria are treated the same.⁵ CMS is also considering issuing guidance to clarify flexibility for plans to offer targeted supplemental benefits to certain enrollees.

APG supports the agency's proposal to create additional flexibility for MA plans to reduce cost sharing and incorporate value-based insurance design principles. Our members' experience has been that patient engagement in their healthcare leads to better outcomes and a more satisfactory experience. The ability to use differential cost sharing and benefits will substantially improve patient engagement and afford our clinicians another tool to ensure that their patients are receiving the right care at the right time in the right setting. We appreciate the additional flexibility and look forward to working with CMS as the agency develops this policy.

II. Coordination of enrollment and disenrollment through MA organizations and effective dates of coverage and change of coverage.

Under current law, the Secretary of Health and Human Services (HHS) has the authority to implement default rules for the MA program. This is in addition to the statutory direction that beneficiaries who do not elect an MA plan are defaulted to traditional Medicare.⁶ In this

² *Id.*

³ *Id.*

⁴ Mandal, et al., Value-Based Contracting Innovated Medicare Advantage Healthcare Delivery and Improved Survival, *Am. J. Manag. Care* 2017:23(2).

⁵ Proposed Rule, at 56,360.

⁶ Proposed Rule, at 56,365.

proposed rule, CMS proposed to codify requirements for seamless default enrollments for certain Medicaid managed care enrollees who become eligible for Medicare. Certain beneficiaries would default into dual eligible special needs plans (D-SNPs). The default enrollment would be subject to five conditions: (1) the individual is enrolled in an affiliated Medicaid managed care plan and is dually eligible; (2) the state has approved use of the default enrollment process and provided Medicare eligibility information to the MA organization; (3) the individual does not opt out; (4) the MA organization provides the individual a notice that meets CMS requirements; and (5) CMS has approved the MA organization to use default enrollment before any enrollments are processed.⁷ The agency states that this default enrollment is particularly beneficial for this population because it promotes enrollment into plans with integrated care.

APG strongly supports the use of default enrollment for enrollees transitioning from Medicaid managed care into D-SNPs. We agree with CMS that this will increase enrollment of dually eligible individuals into fully integrated systems of care and will improve health outcomes as a result.

In the rule, CMS also proposes to establish a new, simplified opt-in election process for all MA organizations for the MA enrollments of their non-Medicare members, including commercial and Medicaid enrollees.⁸ CMS indicates that affirmative elections would be necessary for individuals not enrolled in a Medicaid managed care plan.

We appreciate the agency's proposal to streamline enrollment for beneficiaries. As we described above, our physicians and their care teams believe that, in general, MA offers a superior option for population health. As a result, we strongly support policies that will streamline and simplify MA enrollment. We encourage CMS to take this proposal even further. We believe that an opt-out proposal with beneficiary protections would better meet the needs of patients who become eligible for Medicare. This approach would further simplify and streamline enrollment efforts and would achieve the policy goal of facilitating MA enrollment.

We continue to believe that Congress should revisit automatic enrollment in traditional Medicare. As we outlined in our comments on the MA request for information earlier this year, we believe that, particularly when MA quality is superior, enrollment should default to the highest quality option, rather than to traditional Medicare. While we know this is outside of the scope of this rulemaking, we mention it here as a policy priority going forward.

III. MA 5 Star quality rating system proposals.

In the proposed rule, CMS makes a number of proposed changes to the MA Star Ratings system. We address several of those proposals below:

- a. APG supports the agency's proposal to codify changes to the Star Ratings system beginning in the CY 2019 measurement year.

⁷ Proposed Rule, at 56,366.

⁸ Proposed Rule, at 56,367.

CMS proposes to codify the Part C and Part D Star Ratings system beginning with the CY 2019 measurement year. We have consistently advocated for the use of formal federal register notice and comment rulemaking to make changes to the Star Ratings system and other aspects of MA payment. Formalizing the regulatory approach to MA is a critical step for stakeholder engagement and improving program transparency. Allowing stakeholders additional time to understand the proposals, publishing the proposals in the federal register, and allowing adequate time for comments to be developed and shared with the agency will improve the quality of the feedback CMS receives and therefore the quality of the policy CMS is able to develop. This is especially true for entities downstream from health plans, including clinicians, who may need more time to evaluate proposals and truly understand the business impact. In addition, as MA continues to grow to represent a larger proportion of the Medicare program, affording it the same formal rulemaking process as other aspects of Medicare payment is appropriate and well overdue.

- b. APG encourages CMS to continue to find opportunities to harmonize quality measures across programs.

CMS details its guiding principles for updating the Stars Ratings program, including: alignment with the CMS quality strategy, stability, fairness, completeness, and reliability. CMS requests feedback on opportunities to improve the Star Ratings system, including whether the agency should add a measure of physicians' experiences with health plans.

APG supports the agency's guiding principles. We emphasize the importance of aligning clinical quality measures and specifications across different programs. Our members participate in a wide variety of risk contracts with different payers, including MA plans, traditional Medicare, Medicaid managed care plans, and commercial plans. Each of these payers have different measures sets that they are using to assess quality performance and determine physician organization payment. The use of different quality measures in each contract creates substantial burden on physician organizations. As physician organizations pursue higher levels of risk with multiple contracting partners, alignment across programs is essential to reduce burden and improve the experience for physician organizations.

In addition, as we stated in our response to the agency's request for information in April 2017, we encourage CMS to develop a strategy to provide public facing quality information for physician organizations participating in MA.⁹ Today, seniors enrolled in MA can access information about the quality of their health plan on the plan finder website. Seniors enrolled in traditional Medicare can access information about Part B quality on the Physician Compare site. Yet, no information is available at the physician organization level for groups participating in MA. This omission creates an incomplete picture for beneficiaries who want to access care and an incomplete picture of physician performance, particularly for those physicians who have a sizable percentage of their patient population in MA.

Quality data at the physician group level already exists in the MA Star Ratings program. For example, the Integrated Healthcare Association (IHA) has developed a quality ranking program at the physician group level for the state of California. Using MA measures, IHA creates a Five-Star quality score for the physician group and publishes the results on the IHA website. We

⁹ <http://capg.org/modules/showdocument.aspx?documentid=3731>

encourage CMS to consider how it could similarly post quality information for physician groups participating in MA.

We support the agency's proposal to add a measure that surveys physician experiences with MA plans. As CMS notes, physicians are in close contact with health and drug plans on behalf of their patients and on behalf of their own businesses. A survey tool that collects standardized information could be of high value to CMS, physicians, and plans. We note that surprisingly little information is available about what happens downstream from the health plan contract with CMS. We encourage CMS to move forward with the development of such a tool. We would be pleased to work with CMS to develop meaningful survey questions and we ask that the agency proceed in a way that minimizes burden on individual clinicians.

- c. CMS should use the Five-Star Quality Rating program to develop incentives for advanced APM contracting in Medicare Advantage.

As described above, we know that quality in MA improves when plans engage in value-based contracting with their downstream provider networks. A broad, bipartisan majority in Congress recognized the importance of risk contracting when it passed the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015. As you know, MACRA creates incentives for physicians and physician groups to enter risk arrangements in traditional Medicare and in other payer relationships. However, the MACRA incentives are limited to the physician group's traditional Medicare revenue.

MACRA has succeeded in creating an incentive for physician organizations to move into risk in traditional Medicare. Across the APG membership, we have increasingly seen physician organizations move into risk, whether it be the newly formed Track One Plus model, Next Generation Accountable Care Organizations, or Comprehensive Primary Care Plus. We also greatly appreciate the agency's commitment to create a qualifying Medicare Advantage advanced APM demonstration project under MACRA to allow physicians to qualify for the Part B incentive in 2018. However, given that MA comprises a third of senior enrollment in Medicare and is projected to continue to grow, we believe that more must be done to encourage delivery system transformation.

We call on CMS to use the Five-Star Quality Rating program to differentiate between plans that engage in downstream APM contracts and plans that pay fee-for-service downstream in MA. CMS should develop a MACRA-like incentive for plans and providers that share risk in MA. For example, CMS could add a measure to the Star Ratings program that accounts for the percentage of plan revenue is in a two-sided risk arrangement. This would create a bonus on the Part C revenue, which should be shared equally between plan and provider, with CMS paying at least half of the incentive directly to the Part C provider organization. Such an incentive will accelerate the movement from volume to value and is a critical component in transforming the delivery system.

- IV. APG supports implementation of legislated changes to the MA open enrollment period.

From 2007 to 2010, MA-eligible individuals had a one-time opportunity to make an enrollment change between January 1 and March 31. This "old" open enrollment period (OEP) allowed

new enrollment into an MA plan from traditional Medicare, switches between MA plans, and disenrollment from MA to traditional Medicare. In 2010, the Affordable Care Act (ACA) eliminated the old OEP and instead provided a different enrollment period for enrollees to leave MA for traditional Medicare in the first 45 days of the year. The 21st Century Cures Act modified the statute to create a new open enrollment period from January 1 to March 31 each year. The new OEP allows a one-time election during the first three months of the calendar year to switch MA plans or to disenroll from MA into traditional Medicare. Individuals with enrollment in traditional Medicare are not able to use the new OEP to enroll in an MA plan.

We support the implementation of the new enrollment period, as required by the statute. As stated above, we hope the agency will continue to find ways to encourage and facilitate enrollment in MA plans in the future.

V. APG supports reducing the burden of the compliance program training requirements.

Existing law specifies that Part C and Part D contracting organizations must participate in compliance programs that meet criteria specified by the Secretary. CMS had previously established that first-tier downstream and related entities complete compliance training programs. Downstream entities complained about the burden of having to complete organizations' compliance trainings, indicating that the time spent in these programs took away from patient care. CMS attempted to resolve that burden by developing its own standardized program modules. Effective January 1, 2016, first-tier downstream and related entities were required to complete the CMS training to satisfy the compliance requirement.¹⁰ However, entities subject to this training indicated that the standardized CMS training created additional burden in that many plans still required separate training in addition to the CMS training.

In the proposed rule, CMS would eliminate the compliance requirement pertaining to the first-tier downstream and related entities. The agency indicates that the requirement no longer represents efficient administration of the program. CMS will continue to hold MA organizations accountable for the failures of downstream entities to comply with Medicare program requirements and will audit sponsors compliance programs.

We support the changes proposed in the rule. We agree with the agency's assessment that the CMS training creates additional and unnecessary burden on physician practices and other downstream entities. We also agree that there are sufficient other incentives and safeguards in place to incentivize compliance and to hold plans and downstream contractors accountable for compliance.

VI. APG supports the proposed changes to the rules governing marketing materials.

Existing law prohibits MA organizations from distributing marketing materials and application forms to MA eligible individuals unless the document has been submitted to the Secretary at least 45 days prior to use and has not been disapproved.¹¹ CMS is proposing to narrow the definition of what constitutes marketing materials and to create a broader definition of materials known as communications. Marketing materials would become a subset of communications.

¹⁰ Proposed Rule, at 56,430.

¹¹ Proposed Rule, at 56,433.

Marketing materials would be subject to more stringent requirements, including submission to and review by CMS. Non-marketing materials would fall under less stringent requirements.

We support the agency's proposal to narrow the scope of marketing materials and to create a new category of communications materials. We note that there is a lack of clarity in the existing subregulatory guidance around what clinical communications and other communications by physicians constitute marketing. We believe that there is a valuable role for physicians to speak with their patients about coverage options, particularly if a patient can benefit from coordinated, accountable care in MA. This type of conversation is part and parcel of establishing an engaged patient – a goal we all seek. We suggest a thorough review of the manual provisions and other guidance to ensure that the parameters are clear and that the rules further the goals of advancing capitated, coordinated care. Revamped materials should encourage selection of the best option for the specific consumer and encourage patient engagement. The existing rules were written in a different world, where volume was predominantly incentivized. Today, we need marketing rules that facilitate consumer selection of MA options. The rules should facilitate transparency for beneficiaries and bright lines for physicians and physician organizations.

VII. APG supports eliminating the Medicare enrollment requirement and replacing that requirement with the use of a CMS-developed preclusion list.

CMS proposes to eliminate current regulations that require MA providers to enroll in traditional Medicare.¹² In the place of the enrollment requirement, the agency would develop a preclusion list using a three-step approach to identify certain categories of precluded providers. CMS believes that this approach will better facilitate the goals of reducing physician burden and protecting the Medicare program from risks.

We believe that the approach outlined in the proposed rule will reduce clinician burden in MA and afford sufficient protections to the Medicare program and beneficiaries. The enrollment requirement created additional burden that we viewed as unnecessary and unhelpful. We encourage CMS to finalize the proposal to replace the enrollment requirement with a preclusion list process.

VIII. APG supports the proposed updates to provider incentive plans.

Under existing regulations, MA plans must provide adequate and appropriate stop loss insurance to physicians or physician groups that are taking substantial financial risk under the plan's physician incentive plan (PIP).¹³ CMS proposes modernizing these requirements and affording additional flexibility to plans and providers. CMS proposes three specific changes: (1) updating the stop loss deductible limits and codifying a methodology to update these limits going forward to taking into account changes in medical cost and utilization; (2) authorizing MA organizations to use actuarially equivalent arrangements to protect against substantial financial losses under PIP due to risks associated with certain groups of patients; and (3) allowing non-

¹² Proposed Rule, at 56,444; 56,447.

¹³ Proposed Rule, at 56,461.

risk patient equivalents, such as FFS Medicare patients, to be included when determining the deductible.

We support the proposed modernization and increased flexibility proposed in the rule and encourage CMS to finalize this provision as proposed.

IX. Reducing provider burden arising from medical record documentation by MA organizations.

In the proposed rule, CMS solicits feedback on opportunities to reduce provider burden arising from medical record documentation by MA organizations. Our physicians have identified two areas of improvement in this regard:

First, we encourage CMS to eliminate the requirement that physicians annually document conditions that cannot be cured or reversed. Perhaps the most commonly cited example is the requirement that an amputated limb be re-documented each year. We recommend that CMS eliminate the requirement that certain conditions be documented each year, particularly for those conditions that are irreversible. We would be pleased to work with our chief medical officers to develop a list of appropriate conditions.

Second, we encourage CMS to find ways to improve transparency and consistency across health plans. In our model, individual physicians submit patient risk information to the medical group, the group then submits to the health plan, and the plan transmits information to CMS. Once the data leaves our medical group, there is a lack of clarity as to what information is accepted by the health plan and by CMS. The rejections have been inconsistent across the different plans. Because some of our groups contract with as many as eight health plans for their MA population, these disparate requirements create a substantial amount of burden on medical groups. The result can be payments that are lower than what is warranted for the population. Creating consistent standards across plans is a way to reduce provider burden.

X. Conclusion

We appreciate the opportunity to comment on this proposed rule. We are committed to a strong future for the Medicare Advantage program and its enrollees. We look forward to working with you to grow and modernize the program. Please contact Mara McDermott, Vice President of Federal Affairs (mmcdermott@apg.org) with any questions about this comment letter.

Sincerely,



Donald H. Crane
President & CEO
America's Physician Groups