

November 17, 2017

Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

**RE: Centers for Medicare & Medicaid Services: Innovation Center New Direction**

Dear Ms. Verma:

The Medicare Payment Advisory Commission welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Request for Information (RFI) on the CMS Innovation Center's (Innovation Center) new guiding principles and model focus areas. We appreciate your staff's ongoing efforts to test innovative payment and service delivery models that may reduce program expenditures and improve quality of care, particularly considering the competing demands on the agency.

The Innovation Center's guiding principles to approach new model design include: 1) choice and competition in the market; 2) provider choice and incentives; 3) patient-centered care; 4) benefit design and price transparency; 5) transparent model design and evaluation; 6) small scale testing. The Innovation Center will apply these principles to testing models in the following focus areas: 1) increased participation in advanced alternative payment models; 2) consumer-directed care and market-based innovation models; 3) physician specialty models; 4) prescription drug models; 5) Medicare Advantage innovation models; 6) state-based and local innovation, including Medicaid-focused models; 7) mental and behavioral health models; and 8) program integrity.

Taking into account the new guidelines and focus areas, we briefly describe the following models that the Innovation Center could consider testing.

- Expanding opportunities for advanced alternative payment models through an accountable care organization demonstration
- Part B Drug Value Program
- Medicare Advantage Value-based Insurance Design

## **Expanding opportunities for advanced alternative payment models through an accountable care organization demonstration**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the sustainable growth rate (SGR) system and established a new approach to updating payments to clinicians. It established two paths—one for clinicians who participate in advanced alternative payment models (A-APMs) and another for other clinicians (the Merit-based Incentive Payment System (MIPS)). Beginning in 2019 and continuing through 2024, clinicians on the A-APM path—that is, those who have sufficient participation in an A-APM entity—will receive a 5 percent incentive payment based on their physician fee schedule (PFS) billings for the previous year. From 2026 on, these clinicians, if they still meet the criteria for participation in an A-APM entity, will receive a higher update than clinicians on the MIPS path.

In the RFI, the Innovation Center anticipates that the number of providers interested in participating in an A-APM entity will increase over time. In order to create more opportunities for providers, future models will expand options for participation in A-APM entities. We support encouraging physicians to join A-APM entities that conform to a set of principles that the Commission established to help guide the development and implementation of A-APMs<sup>1</sup>:

- Clinicians should receive an incentive payment only if the A-APM entity in which they participate is successful in controlling cost, improving quality, or both.
- The A-APM entity should be at financial risk for total Part A and Part B spending.
- The A-APM entity should be responsible for a beneficiary population sufficiently large to detect changes in spending and quality.
- The A-APM entity should have the ability to share savings with beneficiaries.
- CMS should give A-APM entities certain regulatory relief.
- Each A-APM entity should assume the financial risk and enroll clinicians.

Adhering to these principles, the Innovation Center could design a new two-sided accountable care organization (ACO) model to expand opportunities for clinician involvement in A-APM entities. This voluntary ACO initiative would increase transparency for participating providers by including prospective beneficiary attribution and benchmarks, similar to the Next Generation ACO demonstration. The new model would also allow beneficiary attestation in which beneficiaries attest that they belong to an ACO, such as through designating a primary care provider that is within the ACO. Consistent with our principles, performance would be judged against a benchmark comprised of total Part A and Part B spending, with a risk corridor (typically calculated as a percentage of the benchmark) limiting the size of potential losses or savings.

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<sup>1</sup> Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Participation in this model could be increased by making the risk corridors asymmetric, meaning that the upper bound on savings could be a greater percentage than the lower bound on losses. However, in an asymmetric model, additional funds will be needed. This is because some ACOs would get shared savings and some would get shared losses from random variation. If the risk corridor had higher upper than lower limits, Medicare could expect to pay out more in unwarranted shared savings than it would collect on unwarranted shared losses.

For smaller clinician practices whose revenue is only a small portion of total Part A and Part B spending, taking on risk for the entire benchmark could be too daunting relative to their revenue. To gain the participation of those clinicians, a model could be designed that bases risk on practice revenue as opposed to the ACO's benchmark (although performance would still be judged on total Part A and B spending). Combined with an asymmetric risk corridor, such a model might engender even greater participation in ACOs. A model with those properties is outlined in the Commission's June 2017 report to the Congress.<sup>2</sup>

The Commission supports incorporating some of the flexibility and tools for beneficiaries and providers that the Innovation Center has implemented in the Next Generation ACO into the new proposed model. For example, the proposed model could include enhanced benefits for beneficiaries, such as the Coordinated Care Reward in the Next Generation ACO, which offers beneficiaries a \$25 incentive when they have their Annual Wellness Visit. The model can also include incentives (i.e., waiving cost sharing) for beneficiaries to use providers affiliated with the ACO, and allow the ACO to share savings with the beneficiary. Like the Next Generation ACOs, this new model should also have added flexibility (e.g., through skilled nursing facility (SNF) 3-day rule waivers or Post-Discharge Home Visit waivers) and choices for providers regarding how they would like to receive claims payment.

Another option to encourage providers to join this new ACO model would be to waive the threshold required to become a qualifying A-APM provider (QP) for the A-APM versus MIPS track. Currently, once providers reach QP status they receive a 5 percent bonus payment that is calculated on their entire FFS revenue. We would instead suggest—similar to our June 2017 report to the Congress—that the thresholds for achieving QP status be eliminated, and all providers that are associated with an A-APM entity would receive a 5 percent incentive payment based on the amount of revenue coming through their A-APM. Waiving the thresholds would eliminate the payment cliff, while also encouraging A-APM involvement by making the incentive proportional to providers' A-APM involvement. This could be tested in different markets and applied not only for those within the ACO demonstration suggested here, but also for providers in other A-APM entities within the specified market. Eliminating the threshold for A-APMs across an entire market would ensure similar incentives for all A-APM entities.

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<sup>2</sup> Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

## **Part B Drug Value Program**

Medicare Part B covers drugs that are administered by infusion or injection in physician offices and hospital outpatient departments. It also covers certain drugs furnished by suppliers. Medicare Part B drug spending has been growing rapidly. Concern exists about the overall price Medicare Part B pays for drugs and the lack of price competition among drugs with similar health effects. In our June 2017 report to the Congress, the Commission recommended that the Congress implement a voluntary, market-based alternative to the current average sales price (ASP) payment system for physicians and hospitals.<sup>3</sup>

The Innovation Center could test a small-scale, market-based alternative, or Part B Drug Value Program (DVP), which would allow providers in specified markets to voluntarily enroll and would use private vendors to negotiate drug prices with manufacturers. The intent of the DVP would be to obtain lower prices for Part B drugs by permitting private vendors to use tools (such as formularies and, in certain circumstances, binding arbitration) to negotiate prices with manufacturers and by improving incentives for provider efficiency through shared savings opportunities. Providers that chose to enroll in the DVP would continue to buy drugs in the marketplace but at the DVP-negotiated price, and Medicare would reimburse those providers at the same negotiated price. To encourage enrollment in the DVP, providers would have shared savings opportunities through the DVP while for providers in that market not participating in the DVP, the ASP add-on would be reduced gradually in the ASP system. Savings achieved through the DVP would also be shared with beneficiaries (through lower cost sharing) and with DVP vendors and Medicare.

## **Medicare Advantage Value-based Insurance Design**

The Innovation Center's new direction seeks to provide Medicare Advantage (MA) plans the flexibility to innovate and achieve better outcomes. In January 2017, the Innovation Center started testing the Medicare Advantage Value-Based Insurance Design (VBID) model in seven states. Eligible MA plans in these states, upon approval from CMS, can offer varied plan benefit designs for enrollees with certain clinical conditions (e.g., diabetes, congestive heart failure, hypertension). The Innovation Center's RFI states that the VBID model could be modified to provide more flexibility to MA plans and potentially add additional states.

The Commission has recommended that the Congress permit MA plans to develop benefit designs that vary based on the medical needs of individuals with specific chronic or disabling conditions (e.g., vary the supplemental benefits, cost sharing for services and drugs, and provider networks for chronically-ill enrollees).<sup>4</sup> Therefore, we support the Innovation Center continuing to test benefit design flexibility for MA plans through models like the VBID.

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<sup>3</sup> Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

<sup>4</sup> Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC

## **Conclusion**

The Commission appreciates the opportunity to comment on the models that could be tested through the Innovation Center. We also value the ongoing cooperation and collaboration between CMS and Commission staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, the Commission's Executive Director, at 202-220-3700.

Sincerely,

A handwritten signature in black ink that reads "Francis J. Crosson M.D." in a cursive script.

Francis J. Crosson, M.D.  
Chairman