Executive Summary: Medicare Advantage (MA) Plus Proposal

The MA Plus Model is a proposal submitted to the CMS Innovation Center that is designed to be the future of Medicare service delivery. Built upon the popular MA chassis, this provider integrated model seeks to promote the delivery of high-quality care to Medicare beneficiaries and promote economic efficiency in the Medicare Program. The Model respects the provider-patient relationship, offers a superior beneficiary experience as designed by providers and their patients, and removes barriers to delivering care that is high-quality, convenient, requested and timely.

Need

Medicare costs are a growing percentage of the federal budget. Congress and regulators have mandated that the healthcare industry move to value and increasingly tie payment to quality and health outcomes. Providers are overwhelmed with increasing healthcare regulations and desire to move to a stable payment environment. Seniors in rural areas and elsewhere want affordable access to healthcare and fear reductions in coverage.

Solution

The Medicare Advantage program is an increasingly popular option for seniors and has shown promise in curbing costs, quality outcomes and offering supplemental benefits desired by seniors. Medicare ACO models have succeeded in offering a differentiated patient experience through enhanced provider engagement and testing benefit enhancements and programmatic waivers. By further enabling MA with ACO best practices, the MA Plus Model will enhance healthcare access, provide high-quality care and offer fiscal relief to the Medicare program. The Model prioritizes choice in healthcare, encourages marketplace competition and assists the government by lessening its role in healthcare administration.

The MA Plus Model is proposed as a five-year pilot. Model features include:

- Eligibility limited to provider integrated MA plans, which require collaboration with a Medicare ACO and meaningful provider representation on the plan's governing body.
- Attribution-based enrollment of beneficiaries related to their alignment with Medicare ACOs is utilized with affirmative election to remain in Fee-For-Service Medicare.
- Network adequacy requirements will allow alternative high-quality standards for tele-health and Center of Excellence designations.
- The MA program will serve as the chassis – current MA payment rates and regulatory structure, except as to enrollment methodology and as otherwise defined in the proposal.
- Tailored beneficiary communication strategy and outreach related to plan benefits, cost and enrollment process will be implemented. Marketing to non-attributed ACO beneficiaries is prohibited.
- ACO risk scores for enrolled members will be utilized for the MA Plus plan in initial years.

- Quality performance will be measured under the MA star measurement and rating system, with initial plans deemed as 3-star plans unless heightened ACO quality performance merits a 4-star rating.
- Regulatory flexibility and applicable fraud and abuse waivers will apply to enable benefit enhancements and other practice flexibility.
- A-APM status will be available for this Model – MA Plus plans will complete the All Payer Combination Option application and MA Plus revenue and patient count will be considered as part of the "Medicare Only" threshold needed to maintain A-APM status under MACRA.

For affiliated ACOs, this Model proposes protections to address concerns that could stem from a reduction in beneficiary count as a result of attribution-based enrollment in the MA Plus plan. These protections include waivers of minimum beneficiary count requirements; recalculations of the minimum savings rate; rebasing the benchmark; partial forgiveness of advance payment model obligations; recalculation of population based payment; ability to switch to lesser MSSP program tracks; and ability to withdraw from the ACO program.

Hypotheses

Under the auspices of the CMS Innovation Center, the Model proposes to test the following hypotheses:

- Heightened levels of beneficiary satisfaction are associated with the MA Plus Model;
- Attribution-based enrollment into the MA Plus Model is an accepted process for beneficiaries to transition from Fee-For-Service Medicare;
- The MA Plus Model is a preferred avenue for providers to enter into risk-based contracts, and transition to value-based payment; and
- Alternative mechanisms to achieve network adequacy for the MA Plus Model promote enhanced healthcare access and increase the adoption of MA plans in rural areas.

Timeline

CMS is requested to consider this proposal for a 5-year pilot period under the CMS Innovation Center. As proposed, the pilot period will start January 1, 2019 and will conclude on December 31, 2023. Applications for participation will be accepted on an annual basis.

Proposal for Medicare Advantage (MA) Plus

I. INTRODUCTION

The Medicare Advantage (MA) Plus Model is proposed as a nimble MA model based on heightened provider engagement for healthcare access, quality and cost. This proposed innovative model is designed to combine and synergize the knowledge gained from high-performing Medicare Accountable Care Organizations (ACOs) and Medicare Advantage (MA) plans. Built upon the popular MA chassis, the model seeks to promote the delivery of high quality care to Medicare beneficiaries while better assuring economic efficiency to the Medicare Program. Through provider integrated plans, this Model better aligns the economic interests of the providers providing the direct patient care services, emphasizes shared decision-making between beneficiaries and providers, thus heightening enrollee engagement, and employs an attribution-based enrollment mechanism for selected high-quality plans. This Model is a platform for improved quality and outcomes and reduced cost.

The hypotheses proposed to be tested are:

- Heightened levels of beneficiary satisfaction are associated with the MA Plus Model;
- Attribution-based enrollment into the MA Plus Model is an accepted process for beneficiaries to transition from Fee-For-Service Medicare;
- MA Plus Model is a preferred avenue for providers to enter into risk-based contracts, transition to value and thereby control costs; and
- Alternative mechanisms to achieve network adequacy promote enhanced healthcare access and increase the adoption of MA plans in rural areas, giving rural citizens more healthcare choices.

CMS has the authority to conduct this Model test through the Center for Medicare and Medicaid Innovation (Innovation Center) under Section 1115A of the Social Security Act.

II. POLICY PURPOSE AND COMPARATIVE RESEARCH

A. Purpose

HHS wants to disrupt; we want to disrupt

The Secretary has expressed a willingness to disrupt current payment mechanisms to ensure the long-term viability of the Medicare program.[1] Likewise, the collaborative group of health systems[2] interested in this Model seek to build upon their history of innovation. The proposal builds upon the

[1] In speeches that were delivered separately to the Federation of American Hospitals on March 5, 2018, and America's Health Insurance Plans on March 8, 2018, HHS Secretary Alex Azar outlined his vision for a "radical reorientation" of the American health care system. The Secretary declared that he is "determined that we look back at the years of this Administration as an inflection point in the journey toward value-based care," and he warned the groups that he will be "unafraid of disrupting existing arrangements simply because they're backed by powerful special interests." https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html;https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/value-based-transformation-of-americas-healthcare-system.html

[2] In addition to UnityPoint Health, collaborators in support of this proposal are: Ascension; Banner Health Network; Cone Health; and Memorial Hermann Health System, Houston, Texas.

seasoned Medicare Advantage (MA) model and blends it with attributes of less-weathered Accountable Care Organizations (ACO) models developed and implemented by the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare & Medicaid Innovation (the Innovation Center). The result, we propose, is a high-value provider integrated MA model with attribution-based enrollment, tied to an individual's history receiving primary care services. This Model provides the best design of care for Medicare seniors in regard to quality of care and patient satisfaction and experience paired with a program cost structure that provides incentives to providers in the areas of quality and cost accountability and enables the government to have greater cost certainty and sustainability in the Medicare program.

Every Administration wants Medicare to provide high quality care, high patient satisfaction and experience at a sustainable price tag

Both the current Administration[3] and the past Administration[4] have endorsed the premise that care for Medicare seniors should be high quality and patient focused. At the same time, both current and past Administrations have struggled with the trajectory of program spending as projected into the next decade.[5] Neither large-scale MA plans nor ACOs have cracked the code to simultaneously achieving each of these elements; however, from the comparison that follows, each model has succeeded better over the other when the elements are looked at separately.

Controlling and Predicting Spending (winner = MA plan structure)

Managed care, whether through an MA model or an ACO model, is intended to achieve cost savings in Medicare. The approach is dominant in most state Medicaid programs, with over 80 percent of beneficiaries in the U.S. receiving their healthcare through some type of managed care.[6] Such value-based care arrangements have led to lower costs and improved survival rates.[7]

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[3] *See footnote 1.* Secretary Azar laid out a plan under which HHS will strive to spur value-based transformations of the health care industry in four areas by, among them:

- Using experimental models in Medicare and Medicaid to drive value and quality "throughout the entire system."
- Removing "any government burdens" that impede this value-based transformation. Azar pointed to "certain Medicare and Medicaid price reporting rules," current interpretations of various anti-fraud protections, restrictions on the coverage of wraparound services like transportation, and provider reporting requirements as examples of the regulations he plans to address.

[4] In 2010, Don Dr. Berwick spelled out his policy goals under three overarching points, which he dubbed his "Triple Aim" plan: Better care for individuals by focusing on safety, effectiveness, patient-centeredness, timeliness, efficiency and equity.

[5] Medicare spending was 15 percent of total federal spending in 2016, and is projected to rise to 17.5 percent by 2027. The Medicare Hospital Insurance (Part A) trust fund is projected to be depleted in 2029. Cubanski, J. & Neuman, T., *The Facts on Medicare Spending and Finance*, The Henry J. Kaiser Family Foundation, July 18, 2017, https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/

[6] As of March 2017, 36 states and Washington, D.C. were utilizing Medicaid managed care plans to in whole or part administer their programs. *J.D. Power Finds Medicaid Enrollees More Satisfied Than Commercial Health Plan Members*, July 31, 2017, http://www.jdpower.com/press-releases/jd-power-2017-managed-medicaid-special-report

[7] "Our report estimates that the MCO model delivered nationwide Medicaid savings of $7.1 billion in 2016, assuming that provider unit prices paid by Medicaid MCOs are equivalent in the aggregate to Medicaid fee-for-service (FFS) levels. The $7.1 billion figure represents an overall savings of 2.6% on all the funds paid via capitation. The 10-year savings from existing capitation programs across the 2017-2026 timeframe are projected to total $94.4 billion." In addition, it led to improved survival rates. Mandal, Aloke K., Tagomori, Gene K., Felix, Randell V. et. al., *Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival*. American Journal of Managed Care 23(2): e41-e49. February 2017.

When looking to assess whether ACOs, as a form of managed care, have resulted in cost savings to the Medicare program, we look to the recent work of Avalere. Their recent research study shows that ACO net savings have fallen short of initial CBO projections by more than $2 billion.[8] In 2010, the CBO projected that the Medicare Shared Savings Program (MSSP) would produce $1.7 billion in net savings to the federal government from 2013 to 2016. However, the MSSP increased federal spending by $384 million over that same period, a difference of more than $2 billion. While the report suggests that more experienced ACOs and those accepting two-sided risk may help the program to turn the corner in the future, the long-term sustainability of savings in the MSSP is unclear.[9] ACOs must move to downside risk much faster for the program to generate savings.[10] The flawed benchmark methodology of the current ACO programs makes future spending projections unpredictable.[11]

By contrast, as of 2017, with the new ACA capitation benchmarks for MA plans fully phased-in, the plans appear to be meeting the expectation of the government in regard to spending, with costs ranging from 95% of Original Medicare in the top quartile of counties with relatively high per capita Medicare costs, to 115% of Original Medicare in the bottom quartile of counties with relatively low per capita Medicare costs.[12] When contrasted to ACO program success, policymakers seem satisfied with the spending, with legislators campaigning on the proposition that MA helps keep cost down for seniors and the government.[13] One of the main advantages in cost savings for MA is the comparative ease for the government in administering the program as opposed to performing the back office functions associated with operating Fee-For-Service Medicare.

Quality of Care (tie between MA plans and ACOs)

Both ACO programs and MA plans show an increase in quality of care for Medicare beneficiaries over Original Medicare.

Quality performance has been strong among ACOs,[14] and quality is not being sacrificed for savings—

https://www.communityplans.net/research/the-menges-group-potential-savings-of-medicaid-capitated-care-national-and-state-by-state-estimates/

[8] Seidman, J., Feore, J., and Rosacker, N. *Medicare Accountable Care Organizations Have Increased Federal Spending Contrary to Projections That They Would Product Net Savings*. Avalere. March 29, 2018, http://avalere.com/expertise/managed-care/insights/medicare-accountable-care-organizations-have-increased-federal-spending-con

[9] *Id.* John Feore, director at Avalere Health

[10] Bielamowicz, L. ACOs Sill Aren't Saving Money for Medicare. April 5, 2018. https://gisthealthcare.com/acos-still-arent-saving-money-medicare/ ; Seema Verma has been quoted as stating that downside risk is the way to take cost out of the Medicare system in presentations to healthcare executives. Morse, S. *ACOs that take on downside risk save Medicare money, but the majority would rather leave*. Healthcare Finance. May 7, 2018. http://www.healthcarefinancenews.com/news/acos-take-downside-risk-save-medicare-money-majority-would-rather-leave

[11] Seidman, *op. cit.*; Morse, *op. cit.*

[12] *Medicare Advantage,* The Henry J. Kaiser Family Foundation, October 10, 2017, https://www.kff.org/medicare/fact-sheet/medicare-advantage

[13] Statement of U.S. Representative Paul Gosar, Arizona, *Talk of the Town: Why I Support Medicare Advantage*, The Daily Courier, March 20-2018, https://www.dcourier.com/news/2018/mar/20/talk-town-why-i-support-medicare-advantage/

[14] Longitudinal examinations of ACO quality have found that ACOs were associated with reduced utilization of post-acute care (PAC), length of skilled nursing facility (SNF) stays, mortality, readmissions, and chronic obstructive pulmonary disease or asthma admissions, and improved patient experience, chronic disease management, and preventive and pediatric care, especially among populations with low socioeconomic status. Bleser, W., Saunders, R., Muhlstein, Dl, Morrison, S., Pham, H. and McClellan, M. *ACO Quality Over Time: The MSSP Experience and Opportunities for System-wide Improvement*. The American Journal of Accountable

as those ACOs who earned bonuses had higher quality scores.[15] Pioneer ACOs showed improvements in 28 of 33 quality measures and experienced average improvements of 3.6 percent across all quality measures. MSSP ACOs that reported quality measures in 2013 and 2014 improved on 27 of 33 quality measures. In addition, MSSP ACOs achieved higher average performance rates on 18 of the 22 Group Practice Reporting Option Web Interface measures reported by other Medicare Fee-For-Service providers reporting through this system.[16]

Likewise, MA plans provide "substantially higher quality of care" compared to Original Medicare, outperforming Medicare Fee-For-Service on all 16 clinical quality measures.[17] MA plans have generally reduced hospital readmission, institutional post-acute care admissions and increased rates of annual preventive care visits and screenings.[18]

Patient Satisfaction and Experience (winner = ACOs)

For many ACOs, lowering the cost of care for Medicare patients was not the main reason they joined the program.[19] Rather, ACO Participants were seeking to "do the right thing." The ability to receive the data from CMS on attributed lives was a way to target care improvements for patients. The receipt of a shared savings check has been an added bonus. This attitude shines through in studies of how ACOs impact patient satisfaction and experience. A New England Journal of Medicine study found that, after ACO contracts began, patient reports of timely access to care and their primary physicians being informed about specialty care differentially improved in the ACO group—ACOs were navigating the fragmented healthcare systems for their members.[20] The success ACOs have had in improving patient experience and satisfaction has been witnessed by the submitters of this proposal. The full embrace of this patient-centered approach is evident in the most recent versions of the ACO CAHPS Surveys on Patient Satisfaction, which were developed by CMS based on feedback from stakeholders. The survey scores upon 9 to 12 core measures patient satisfaction and experience.[21]

In contrast, patient satisfaction and experience may be an opportunity for improvement for MA plans, as the makeup of the 2017 Medicare CAHPS Survey is not heavily weighted on patient

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Care. March 2018. http://www.ajmc.com/journals/ajac/2018/2018-vol6-n1/aco-quality-over-time-the-mssp-experience-and-opportunities-for-systemwide-improvement

[15] Bielamowicz, *op. cit.*

[16] Sean Cavanaugh, *Are Medicare ACOs Working? Experts Disagree*. Healthcare IT News. October 22, 2015. http://www.healthcareitnews.com/news/are-medicare-acos-working-experts-disagree

[17] Timbie, Justin 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 52(6), Part I: 2038-2060. December 2017.

[18] Lemieux, J., Sennett, C., Wang, R., Mulligan, T., and Bumbaugh, J. *Hospital readmission rates in Medicare Advantage plans*. American Journal of Managed Care 18(2):96-104, February 2012.

[19] Bielamowicz, *op. cit.*

[20] *See* McWilliams J., Landon B., Chernew M., and Zaslavsky A. *Changes in patients' experiences in Medicare Accountable Care Organizations*. New England Journal of Medicine. 371(18):1715-1724. 2014.

[21] The CAHPS Survey for ACOs expands on the measures generated by the core CAHPS Clinician & Group Survey. In 2016, CMS accepted results for two versions of the ACO Survey: ACO-9 and ACO-12. The measures included (a) Getting Timely Care, Appointments and Information (core; ACO-9; ACO-12) (b) How Well Providers Communicate (core; ACO-9; ACO-12); (c) Care Coordination (core; ACO-12); (d) Courteous and Helpful Office Staff (core; ACO-9; ACO-12); (e) Patient's Rating of Provider (core; ACO-9; ACO-12); (f) Access to Specialists (ACO-9; ACO-12); (g) Health Promotion and Education (ACO-9; ACO-12); (h) Shared Decision Making (ACO-9; ACO-12); (i) Health Status/Functional Status (ACO-9; ACO-12); (j) Between Visit Communication (ACO-12); (k) Helping You to Take Medication as Directed (ACO-12); and (l) Stewardship of Patient Resources (ACO-9; ACO-12).

satisfaction and experience.[22] Further, studies have shown that MA plans are lacking in the factors driving overall satisfaction—namely coordination of care among doctors and other healthcare providers. On average, just 34% of MA plan members indicate their plan met this criterion.[23]

We believe that provider integration with MA plans is the key to unlocking higher beneficiary satisfaction with the MA program and higher acceptance of Medicare managed care, in general. This truth is underscored by the fact that provider integrated MA plans, like Kaiser, rank the highest in MA member satisfaction.[24] Ensuring members see their doctor as a trusted partner in their medical care is the most important factor in driving the highest levels of overall satisfaction with MA plans.[25] This sentiment is echoed in a recent report by Senator Cassidy, "Patients do better when they have a relationship with a doctor or affiliated practitioner. Costs decrease when the providers and/or the patients have a financial incentive to control costs [according to a Commonwealth Fund report]. Physicians are best positioned to control cost and improve outcomes. Practice models that capitalize on this must be enabled."[26] The most valued feature in the patient/provider partnership is the assistance patients receive from their provider in navigating a myriad of healthcare providers and associated healthcare costs. This was also a key finding in our own beneficiary interviews.[27]

B. Proposal Overview

Combining the Ability of the MA Program to Offer Predictability in Cost with the ACO's Ability to Offer a Differentiated Patient Experience is the Key to Success

We believe our proposal will result in greater quality, patient experience and satisfaction and cost improvements through provider integrated MA plans. Providers already operate many of the highest-quality MA plans in the marketplace, based on the CMS' star ratings system. *Most of the 16 plans with five-star ratings for 2015 are operated by providers or integrated delivery systems*.[28]

Our proposed model seeks to improve and build on the current structure of provider integrated plans by offering the following improvements:

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[22] Compare to the MA CAHPS Survey which includes: (a) Getting Needed Care; (b) Getting Appointments and Care Quickly; (c) Doctors Who Communicate Well (*reported to contracts – not reported to consumers*); (d) Customer Service; (e) Care Coordination; (f) Rating of Health Plan; (g) Rating of Health Care Quality; (h) Annual Flu Vaccine; and (i) Pneumonia Vaccine (reported to contracts – not reported to consumers). www.MA-PDPCAHPS.org

[23] J.D. Power, *op. cit.* The study, now in its third year, measures member satisfaction with Medicare Advantage plans—also called Medicare Part C or Part D—based on six factors (in order of importance): coverage and benefits (25%); customer service (19%); claims processing (15%); cost (14%); provider choice (14%); and information and communication (12%). The 2017 Medicare Advantage Study is based on the responses of 3,442 members of Medicare Advantage plans across the United States.

[24] *Id.* Kaiser outperforms all other plans across five of the six factors that comprise the overall satisfaction index.

[25] *Id.*

[26] Senator Bill Cassidy, M.D. *Ideas to Make Healthcare Affordable Again*. May 29, 2019, https://globenewswire.com/news-release/2018/04/10/1467897/0/en/Ten-Insurers-Have-72-Of-The-Medicare-Advantage-SNP-Marketshare-OPEN-MINDS-Releases-2018-Update-On-Medicare-Special-Needs-Plans.html; citing in part, Friedberg, M., Rosenthal, M., Schneider, E, Werner, R., and Volpp, K. *Effects of a Medical Home and Shared Savings Intervention on Quality and Utilization of Care*. The Commonwealth Fund. June 1, 2015. http://www.commonwealthfund.org/publications/in-the-literature/2015/jun/effects-medical-home-intervention-on-quality

[27] See *III.D.1 Beneficiary Interviews* of this proposal

[28] Herman, B. *More Health Systems Launch Insurance Plans Despite Caveats*. Modern Healthcare. April 4, 2015. http://www.modernhealthcare.com/article/20150404/MAGAZINE/304049981

- Attribution-based enrollment in MA of ACO attributed lives which will allow a broader number of Medicare beneficiaries the enhanced care experience that can take place in a provider integrated MA plan;
- Incorporation of the experience, satisfaction and clinical process improvements developed in ACO models;
- A turn-key option for providers to participate in an Advanced Alternative Payment Model that meets the requirements of MACRA;
- Bringing the sustainability and predictability of the cost of the MA program to the ACO programming; and
- A design that enhances access to providers and choice of services to rural and underserved geographies.

This proposal seeks to enhance the current MA program by squarely placing the patient and their doctor at the center of the healthcare value equation.

Why Neither ACOs or Provider Integrated MA Plans Have Flourished and Why CMS Should Engage This Proposal to Change That

The most disruptive feature of this proposal is for CMS to facilitate enrollment of ACO beneficiaries into high-quality MA Plus plans through attribution-based enrollment. This enrollment process is necessary for three reasons.

First, and most importantly, healthcare will be transformed. Beneficiaries and taxpayers will receive the greatest savings, highest quality and best patient experience when providers have the aligned economic incentive to reduce costs, and provide quality care with top patient experience.

The provider integrated MA model that we are proposing combines exemplary patient satisfaction and overall quality capabilities inherent in provider delivery systems with the added, significant economic savings capability that only provider-integrated entities can provide: the alignment of economic incentives for the greatest and most important share of the care delivery model (and the largest Medicare expense), Medicare Parts A and B. Physicians make decisions that control 87 percent of health care costs and the alignment of incentives increase physician engagement.[29] This economic alignment offers the greatest likelihood of achieving more predictable and efficient care delivery for Medicare beneficiaries.

This foundation of high value care is coupled with an annual attribution-based enrollment process for choosing Medicare coverage. Instead of today's indiscriminate automatic default to Original Medicare regardless of cost or quality concerns, this proposal offers the ability for this default option to match a beneficiary's healthcare preferences as defined by their use of primary care services. By default, a beneficiary would be enrolled with a high-quality provider integrated MA plan that includes their primary care providers with whom they have an existing relationship – they are transitioning to the same physician they have already chosen. It should also be emphasized that attribution-based enrollment in no way limits beneficiary choice; in fact, they are free to opt out during the annual

[29] Akosa, A. *Physician Engagement is Critical to the Success of Any Accountable Care Organization*. Journal of Managed Care Medicine, 16(3):67-76. https://www.namcp.org/journals/jmcm/articles/16-3/Physician_engagement.pdf

election period and they may also dis-enroll during open enrollment. As the default option, attribution-based enrollment only occurs when the beneficiary does nothing. Based on an assumption that applied a default choice of the highest value plan for each beneficiary in their area, this process in itself has been projected to result in an average annual savings of $1,704 in premiums per beneficiary as well as an estimated $57.3 billion over ten years to the government.[30] While this Model is more limited in scope and we cannot attest that the quality rating will be the highest in each area, the potential for savings just from the enrollment process still exists. As further described below, this transition has not and will not occur in the marketplace without policy encouragement and disruption in the form of attribution-based enrollment, which makes MA the default enrollment option, instead of Fee-For-Service. The logical starting point for this policy is provider integrated MA plans, who have high quality outcomes and are themselves disruptive in seeking value and redefining the care experience.

Second, the ACO models are riddled with structural flaws that make their future uncertain. Attribution-based enrollment of ACO beneficiaries into established provider integrated MA plans brings stability to their coordinated care plan.

The benchmark methodology of shared savings is flawed, in that shared savings models will not produce long-term savings. The ACO program is structured to give a bonus to high-cost providers who reduce spending, not reward cost-efficient providers who enter the program and keep costs down. An analysis of 2015 performance shows just how powerful the benchmark is: ACOs who generated savings not only had higher benchmarks, but also had higher per-capita spending than those ACOs who surpassed their benchmarks.[31] CMS is trying to address this by applying regional benchmarking, but this has proven challenging as well.[32]

Our proposal will facilitate a way for providers to move their business into risk-sharing contracts. As shown in *Exhibit 01*, enrollment, revenue, income and margin are directly correlated to time in the market.[33] Provider integrated MA plans struggle to survive because generally they cannot attain the membership needed to achieve the economies of scale administratively nor can they reach

Exhibit 01 Overview of Provider-Sponsored Health Plans, By Year of Commenced Business

Decade Commenced Insurance Business	Number of Active Health Plans	Median Enrollment, 2015	Median Revenue, 2015	Median Net Income, 2015	Median Margin, 2015
Pre 1980	13	245,559	$1,270,628,609	-$5,086,737	-0.5%
1980-1989	29	176,257	$829,904,664	$3,639	0.0%
1990-1999	43	73,201	$360,244,999	-$113,061	-0.1%
2000-2009	24	19,266	$121,895,218	$2,287,345	2.4%
2010-2016	33	4,084	$5,315,694	-$2,618,254	-25.5%

[30] Avalere Health, "Estimated Federal and Beneficiary Impact of Medicare Default Choice to High-Value Plans," Memo to Third Way, December 16, 2014. http://www.thirdway.org/report/medicaresavings-medicare-enrollment; See also "Final Scoring Memo: Default Choice," Actuarial Research Corporation, Memo to Third Way, March 17, 2015. http://www.thirdway.org/report/nationalhealth-expenditure-savings-medicareenrollment

[31] Bielamowicz, *op. cit.*

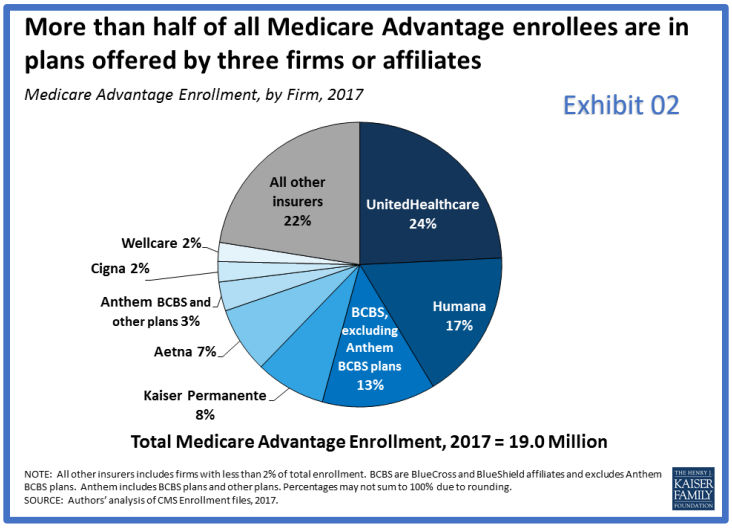
[32] *Id.*

[33] Baumgarten, A. *Analysis of Integrated Delivery Systems and New Provider-Sponsored Health Plans*, Robert Wood Johnson Foundation, June 2017, https://www.rwjf.org/content/dam/farm/reports/reports/2017/rwjf437615

the membership necessary to credibly spread risk.[34] On the commercial side of the industry, insurers have not been receptive to sharing risk with ACO partners.[35] Providers in rural areas who are genuinely motivated to move their business model to total-cost management have been stymied by the lack of receptivity in the commercial market—a critical failing as it is nearly impossible to change the financial and care model of a provider group or hospital on the Medicare book of business alone. It was incorrectly assumed that commercial payers would move toward provider risk in lock-step with Medicare's ACO policy. From our experience, insurers largely view risk-bearing provider organizations as competitive threats, not partners in population health. Consequently, we believe it is imperative for CMS to build a pathway for providers to move material numbers of lives into risk-bearing models that contain sound benchmarking methodology like MA.

Third, without disruption, beneficiary choice of MA plans and their associated supplemental benefits will continue to be limited in any market which is controlled by a handful of non-provider owned, insurance players.

The market share for MA is highly concentrated among a few key players. In 2017, UnitedHealthcare, Humana, and the BCBS affiliates (including Anthem BCBS plans) collectively accounted for 57 percent of MA enrollment (see *Exhibit 02*).[36] Further, only eight insurers accounted for about three-quarters (77%) of the market, including UnitedHealthcare, Humana, Blue Cross Blue Shield (BCBS) affiliated plans (excluding Anthem), Kaiser Permanente, Aetna, Anthem, Cigna and WellCare. In 2016-2017, major mergers were under regulatory review for four of these firms (Humana with Aetna, Anthem with Cigna).[37] While these mergers did not proceed due to concerns about impact on market competition, plans continue to view acquisitions among their strategies to increase MA membership. During quarterly earnings calls for Q4 2017, Anthem, Humana and WellCare all indicated intentions to capture greater shares of the growing MA market.[38] In particular, it was reported that:



[34] Johnson, G., Lyon, Z., and Frakt, A. *Provider-Offered Medicare Advantage Plans: Recent Growth and Care Quality*. 36 (3) Health Affairs: Delivery System Innovations, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0722

[35] Bielamowicz, *op. cit.*

[36] Jacobson, G., Damico, A., Neuman, T. and Gold, M. *Issue Brief: Medicare 2017 Spotlight: Enrollment Market Update*. The Henry J. Kaiser Family Foundation. June 2017. http://files.kff.org/attachment/Issue-Brief-Medicare-Advantage-2017-Spotlight-Enrollment-Market-Update

[37] *Id.*

[38] Jaspen, B. *Insurers Signal Medicare Advantage Buyouts Ahead*. Forbes, February 12, 2018. https://www.forbes.com/sites/brucejapsen/2018/02/12/insurers-signal-medicare-advantage-buyouts-ahead/#7868b52a1076

- Anthem is finalizing the acquisition of MA plans in Florida, which will add 170,000 MA members this year.
- Humana had almost 2.9 million MA enrollees in 2017 and continues to look at strategic acquisitions to build out its MA capabilities, particularly in the primary care arena.
- With more than 500,000 Medicare Advantage members including a recent acquisition of Universal American Corp, WellCare expects to grow its Medicare and Medicaid lines of business both organically and through acquisitions and Medicare figures prominently in its effort to double Wellcare's size by 2021.

Concentrated market share is also a concern for MA special needs plan (SNP) market. For SNPs, ten insurers represent 72% of the market with UnitedHealthcare leading the pack with a market share of 31%.[39] Members of Congress have recognized the consequences of insurance monopolies on health care costs.[40]

Aside from the direct impact of a concentrated market, new provider plans also face "channel conflict" from legacy MA plans. This references the market competition tension that results when provider health plans directly compete for MA premium dollars and the repercussions when providers subsequently negotiate to participate in legacy MA plan networks.[41] To illustrate, Blue Cross and Blue Shield of Nebraska ended its contract with Catholic Health Initiatives (CHI) in 2017 shortly after CHI entered the insurance business in Nebraska and six other states. According to the CHI CEO, Kevin Lofton, "We don't know for sure it's because we entered the market and got a license approved, but the fact is we're in a pretty rough, intense negotiation with them in terms of the network."[42]

For provider integrated MA plans to gain access to enough lives to make meaningful headway in cost, quality and patient satisfaction and experience, they need facilitated access to a substantial number of lives that, due to the market concentration described above, will not be able to be established in today's closed market and present beneficiary decision-making structure unless ACO attributed Medicare beneficiaries can be enrolled into the MA Plus Model as proposed.

We believe our overall proposal and its disruptive nature is exactly what is needed to deliver high-value care to seniors. Secretary Azar declared that the four "shifts" he outlined are "going to happen, one way or another" and warned that the changes will require "some degree of federal intervention — perhaps even to an uncomfortable degree."[43] He also acknowledged that some may be surprised by such a statement from an Administration that "deeply believes in the power of markets and competition."[44] However, the Secretary argued that government intervention is necessary to facilitate reform in a system where "the status quo is far from a competitive free market in the economic sense of the term."[45] We couldn't agree more and offer this proposal as a step to reshape the future of

[39] *Ten Insurers have 72% of the Medicare Advantage SNP Marketshare*. Open Mind. April 10, 2018. https://globenewswire.com/news-release/2018/04/10/1467897/0/en/Ten-Insurers-Have-72-Of-The-Medicare-Advantage-SNP-Marketshare-OPEN-MINDS-Releases-2018-Update-On-Medicare-Special-Needs-Plans.html

[40] Senator Bill Cassidy, *op. cit.*

[41] Herman, *op. cit.*

[42] *Id.*

[43] *See footnotes #1 and #2.*

[44] *Id.*

[45] *Id.*

Medicare delivery putting patients first with the support of their providers whose economic interests are aligned to better enable care coordination, patient satisfaction and cost efficiency.

III. PROPOSAL DESIGN ELEMENTS

A summary table of this proposal is provided as *Attachment A: MA Plus Model – Comparison with ACOs and MA*.

A. Timing

The MA Plus Model is proposed to begin January 1, 2019 and will run for five years through December 21, 2023. Applications will be accepted on an annual basis, and there will be the opportunity to renew the contract for an additional three-year period.

B. Eligible Participants / Organizations

1. **Initial**: Participation in the MA Plus Model is voluntary. The MA Plus Model should be available to provider integrated MA plans. The plan may be a HMO, HMO-POS or local PPO, as dictated by the local market and beneficiary needs.

   For purposes of this Model:

   a. "Provider integrated MA plans" mean MA organizations at the individual plan or segment level that have or are entering into an integrated/collaborative arrangement with a Medicare ACO. Examples of integrated/collaborative arrangements may include provider-sponsored health plans such as joint ventures or formal partnerships or other collaborative arrangements between ACOs and MA plans that share substantial economic risk and integrate providers/suppliers into health plan processes related to network design, provider contracting, quality and care coordination in order to drive innovation, improve quality and outcomes, and lower costs.

   b. "Medicare ACOs" reference the ACOs under the Medicare Shared Savings Program or the Next Generation ACO (NGACO). For 2018, there are 152 risk-bearing Medicare ACOs (51 Next Generation; 38 MSSP Track 3; 8 MSSP Track 2; and 55 MSSP Track 1+) and 460 non-risk-based Medicare ACOs in MSSP Track 1. These ACOs serve more than 12.6 million beneficiaries and offer a broad pool of potential applicants for this Model to provide a valid and reliable cohort for model testing.

2. **Other Eligibility Considerations**: We encourage CMS to develop a limited list of eligibility criteria in recognition of CMS' desire to have a representative and diverse cohort to enable a robust test of the Model's validity. We also encourage CMS to error on the side of inclusion when considering who is best suited to innovate and be successful out of the gate. Additional eligibility criteria for CMS to consider are:

   - *Governance requirements*: Central to this Model is provider engagement through "meaningful

representation"[46] by network providers on the Health Plan Governance Board that oversees this plan. Studies have found that involving physicians in the governance improves communication, builds provider and clinical staff trust and assures patients that their needs will be considered.[47] CMS may also consider including "meaningful representation" for beneficiaries, which may take the form of board representation or an advisory council.[48]

- *Risk-based capital requirements*: CMS should consider requiring an attestation regarding an organization's capacity to meet additional risk-based capital requirements that may result from significant increases in MA enrollment.
- *Quality performance requirements*: For the MA plan, we recommend that CMS establish minimum standards such as the MAO is not listed as an outlier in CMS's Past Performance Review,[49] the plan's contract has at least a three-star overall quality rating, unless the contract is not rated due to newness or low enrollment, and the plan does not have a "consistently low performing" icon on the Medicare Plan Finder. In terms of the ACO, who is not the applicant, we recommend that CMS treat ACO quality performance as an incentive rather than a prohibition to participation – i.e. attainment of predetermined level of ACO quality performance, like top-quartile performers, may be eligible for an interim 4-star rating.

C. Eligible Beneficiaries / Enrollment

1. **Eligible Beneficiaries**: To simplify beneficiary alignment/assignment, this Model will not create separate eligibility criteria and alignment/assignment processes but will use existing ACO program criteria and processes. For both NGACO and MSSP beneficiaries, relevant ACO performance year 2018 beneficiary lists will be used to determine eligibility for MA Plus performance year 2019. Dual eligible beneficiaries are eligible for enrollment if they appear on the beneficiary list and Model Participants include within the bid. NGACO beneficiaries who are eligible for Model participation are those performance-year aligned beneficiaries for the performance year immediately preceding the MA Plus performance year as determined by the alignment-eligibility requirements applied during the first calendar quarter, including exclusion lists.[50] MSSP beneficiaries who are eligible for MA Plus Model participation are those beneficiaries appearing on the preliminary prospective assignment lists based on the offset assignment window as used to determine prospective assignment for the performance year for Track 3 ACOs immediately

[46] ACOs have similar governance requirements. While Next Generation ACO requires 75% provider representation, it is common for Joint Ventures to have an equal or less governance standard. We would suggest that CMS allow applicants to define and describe how they achieve this governance threshold.

[47] Colla, C., Lewis, V., Shortell, S., and Fisher, E. *First National Survey of ACOs Finds that Physicians are Playing Strong Leadership and Ownership Roles*, Health Affairs, 33(6):964-971, June 5, 2014, http://www.statecoverage.org/files/HA_Physicians_in_ACOs_Survey.pdf

[48] Like "meaningful representation" for providers, we would suggest that CMS allow applicants to define and describe how they achieve this governance threshold.

[49] Link to CMS *Part C and Part D Compliance Actions* webpage which contains Past Performance Review documents, http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDComplianceActions.html

[50] NGACO Alignment is described in Centers for Medicare and Medicaid Innovation "Next Generation ACO Model Benchmarking Methods", Document Number: RTI.NGACO.METHODS.BNMRK.01.00.04, dated December 15, 2015.

preceding the MA performance year.[51] The use of beneficiary lists developed in the first quarter of the performance year preceding the MA Plus performance year will enable CMS and Model Participants to have adequate time to validate beneficiary lists prior to any advanced beneficiary outreach efforts.

2. **Enrollment and Opt-Out Process**: We recommend that the MA Plus Model use an attribution-based enrollment process (also known as deemed enrollment or automatic enrollment in other contexts) for eligible Medicare ACO beneficiaries. Attribution-based enrollment is appropriate for this Model to encourage plan participation and to provide sufficient enrollment levels to evaluate this Model. CMS has used an automatic enrollment mechanism for multiple applications, including passive enrollment in Medicare-Medicaid Plans, auto-enrollment or facilitated enrollment in the Part D prescription drug plan for low-income subsidy beneficiaries and beneficiaries covered under terminating plans, auto-enrollment for individuals enrolled through an Affordable Care Act Exchange, seamless conversion for aged-in beneficiaries with existing coverage relationships to MA plan sponsors, deemed enrollment from non-renewing section 1876 cost plans to a successor affiliated MA plan and passive enrollment for the initial special needs plans (SNPs) offering. States may be permitted to mandate enrollment in Medicaid managed care plans under a Section 1115 demonstration, a Section 1915(b) freedom-of-choice waiver, or a state plan option authorized by the 1997 Balanced Budget Act (BBA, P.L. 105-33).[52]

   Using the relevant ACO beneficiary lists, we suggest that beneficiaries be enrolled in this Model during the annual election period from October 15 through December 7. For the Model's first performance year, we recommend that all eligible ACO beneficiaries be subject to attribution-based enrollment and receive related beneficiary communications. Beneficiary notification should outline that they will be enrolled into the MA Plus plan and will receive benefits through that MA Plus plan unless the beneficiary chooses otherwise during the annual election period for the year. CMS should consider using the content framework that was used for deemed enrollment during the Cost Plan conversion[53], which included:
   - A statement that the beneficiary's attribution to the ACO will be converted into the MA Plus plan;
   - The effective date of the coverage in the converted MA Plus plan;
   - The opportunity for the beneficiary to remain in Original Medicare or select another plan during the annual election period;
   - Information regarding the coverage options available and how to make an enrollment change; and
   - A description of differences between Original Medicare and the MA Plus plan and include specific comparisons of differences in cost-sharing, premiums, drug coverage, and provider networks (section 1851(d)(2)(B)(ii) of the Act).

[51] MSSP Alignment described in Medicare Shared Savings Program, "SHARED SAVINGS AND LOSSES AND ASSIGNMENT METHODOLOGY: Specifications," Version #5, Applicable Beginning Performance Year 2017, dated April 2017.

[52] The Balanced Budget Act does not allow the state plan option to include mandated managed care enrollment for certain populations - certain children with special needs, Medicare beneficiaries, and American Indians.

[53] CMS, *Implementation of the Cost Contract Plan Transition Requirements under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)*, December 7 ,2015, https://www.cms.gov/Medicare/Health-Plans/MedicareCostPlans/Downloads/HPMS_Cost_Contract_Transition_Final_12_7_15.pdf

In second and subsequent Model performance years, we suggest that attribution-based enrollment and beneficiary communications be limited to newly eligible ACO beneficiaries (i.e. individuals who age-in or are newly attributed to the ACO through health care utilization during the current ACO performance year). To avoid confusion, beneficiaries who opt out may not be subject to attribution-based enrollment during the remainder of the Model, although they would be able to voluntarily enroll during subsequent annual election periods if they continued to be attributed to the ACO.

The attribution-based enrollment process could be modeled after the seamless conversion for aged-in beneficiaries with existing coverage relationships to MA plan sponsors[54] and afford an opt out process, in which beneficiaries can elect to remain in Original Medicare and be attributed to the ACO instead of enrolling in the MA Plus plan. The process to opt-out or decline the attribution-based enrollment could include the opportunity to contact the MA Plus plan either in writing or by telephone to a toll-free number. CMS may want to prohibit the ACO and MA Plus plan from discouraging declination. The process to allow for opt-out requests to be accepted may extend up to and including the day preceding the enrollment effective date. CMS review of MA Plus plan communications with beneficiaries could be part of the proposal as described in *III.C.4. Beneficiary Protections* below.

3. **Enrollment Timing**: Enrollment timing for the MA Plus Model may be based on the standard MA schedule. As such, attribution-based enrollment would occur during the annual election period from October 15 through December 7. Beneficiary communications could be limited to those individuals identified on the ACO beneficiary alignment/assignments lists and would conform to timeframes and content as provided in the agreed-upon CMS-Participating Provider communications plans. Any beneficiary who does not "opt out" to Original Medicare during the annual election period would be "deemed" to have enrolled in the MA Plus plan on the following January 1 through an attribution-based enrollment. Additionally, beneficiaries subject to attribution-based enrollment would have the opportunity to switch MA plans or dis-enroll from MA Plus and obtain coverage through Original Medicare during the standard open enrollment period for individuals enrolled in MA, which occurs from January 1 through March 31.[55] For beneficiaries who elect Original Medicare, eligible beneficiaries would remain attributed to Medicare ACOs. The effective dates of these elections are proposed to follow current law.

4. **Beneficiary Protections**: Aside from opt-out provisions and the open enrollment period, safeguards would be in place to limit coverage disruptions and to provide beneficiary outreach regarding coverage changes and the opt-out process. Since this Model uses attribution-based enrollment of ACO beneficiaries based on their primary care use in the ACO, it is likely that their primary care provider relationship in the affiliated MA Plus Plan would remain intact. If the beneficiaries elect to opt out during the annual election or dis-enroll from the MA Plus plan to obtain Original Medicare, beneficiaries would simply revert to Original Medicare and be attributed to the ACO, if eligible, without any coverage disruptions. This reversion would be

[54] Guidance outlined in Section 40.1.4 in Chapter 2 of the Medicare Managed Care Manual
[55] 42 CFR § 422.62(a)(3)

consistent with current law, as beneficiaries are automatically attributed to ACOs based on their primary care service utilization (as defined by E&M billing codes).

As further described in *III.D. Marketing and Beneficiary Communications*, outreach to beneficiaries would be carefully constructed to describe this Model and to support beneficiary choice. Communications to ACO beneficiaries would be subject to CMS marketing requirements to explain the purpose of this Model, its impact on coverage, provider accessibility and availability, out-of-pocket costs including the need for Medicare Supplement Plans, and details of the opt out process. The goal is to promote a process whereby beneficiaries are knowingly enrolled. We intend to collaborate with CMS to determine the appropriate timing/frequency/means of beneficiary communications. Of importance, the MA Plus plan would have limits on marketing and advertising to non-attributed members during the pilot period. This is to balance the impact of attribution-based enrollment on legacy MA plans. This Model is to test attribution-based enrollment with beneficiaries whose healthcare use would suggest alignment with MA Plus Plan primary care providers. Legacy MA plans within the market will continue to advertise and enroll without reference to the MA Plus Model.

Most ACO beneficiaries have a Medicare Supplement or Medi-gap policy, which would not be needed with the MA Plus Model. We propose that MA Plus plan beneficiaries would retain their guaranteed issue rights where the beneficiary chooses to opt-out of the Model during the second or subsequent open enrollment periods or upon termination of the Model. This guaranteed issue right would be described to beneficiaries in enrollment materials. If the beneficiary elects to enroll or has an attribution-based enrollment in the MA Plus plan, the plan should send an enrollment acknowledgement and provide a sample termination letter that may be used by the member to terminate the Medicare Supplement or Medi-gap policy.

C. Plan Design

1. **Coverage**: The MA Plus Model proposes to follow the general MA coverage rules and categories as established under the initial Medicare+Choice program. Specifically, each MA Plus plan would provide, at minimum, the same benefits as required under Medicare FFS. In addition, MA Plus plans would also provide additional benefits and reduced cost-sharing if Medicare's payment to the MA Plus plan is less than the plan's cost of providing the basic Medicare benefits to commercial enrollees. Aside from these mandated benefits, MA Plus plans may offer extra benefits, known as supplemental benefits. If Part D is included within a Medicare Plus plan, then minimum Part D benefits would also be included. This Model is not intended to reduce Medicare coverage for beneficiaries. Instead, this Model will offer these plan services via a provider-driven delivery system with expanded authority to offer alternative and innovative means to provide patient-centered care and encourage/incent patient engagement.

2. **Additional Benefits**: Beneficiaries will have the opportunity to shape the future of Medicare benefits. The Model is intended to offer benefits tailored to its local members, with additional opportunities afforded to Model Participants to participate in the supplemental benefits that are characteristic to the Next Generation ACO program through the Innovation Center (i.e. waivers of certain Medicare service rules to improve care for and engagement of beneficiaries).We believe this expanded authority fits well with ACO best practices, as ACO interventions have often

targeted high-risk beneficiaries.

Benefit Enhancements: Under the auspices of the Innovation Center, Next Generation ACOs have developed a ready and tested toolkit to help providers engage beneficiaries in their care through benefit enhancements that directly improve the patient experience. These benefit enhancements include telehealth, post-discharge home visits, three-day skilled nursing facility rule, as well as three recently announced benefit enhancement authorities for cost sharing support for Part B, chronic disease management reward and care management home visits. These program enhancements emphasize high-value services, support care management and closer care relationships, allow provider flexibility, promote communication to beneficiaries and evaluate enhancement utilization and impact. Because of the

We request that MA Plus Model Participants be allowed to test benefit enhancements in a similar fashion to the Next Generation ACO. This would include benefit enhancements authorized in the future if consistent with MA Plus plan activities and approved by the governing board. This would assure that ACO beneficiaries would be placed in an equivalent benefit position under the proposed MA Plus Model. In addition, this would permit providers who had helped to shape these enhancements to continue to include them within their care options. For instance, both the post-discharge home visits and the care management home visits have been found to be valuable for individuals not meeting home-bound requirements for home care. As for the chronic disease management reward, this incentive could be used for many purposes such as phased encouragement for the Medicare Diabetes Prevention Program (i.e. $25 as participants successful complete each third of the 52-week program).

3. **New Bid**: To actualize the differentiated plan, we propose that Model Participants be allowed to submit a new bid for the attribution-based enrollees which will enable the MA Plus plan to reconfigure its service area, network and supplemental benefits in a manner which suits the pilot population. These benefits would vary based on the local needs identified by the MA Plus plan as informed by past ACO learnings. For instance, supplemental benefits may include provision of telehealth equipment to beneficiaries with chronic diseases at reduced or no cost; reduced cost sharing for high-value services, such as eye exams for diabetics; reduced cost sharing for enrollees participating in disease management or related programs, such as cardiac rehab; and/or transportation to follow-up appointments for certain medical diagnoses at no cost.

D. Marketing and Communications

1. **Beneficiary Interviews**: In May 2018, key informant interviews were conducted[56] with Medicare beneficiaries who have professional and personal experience with the Medicare program. Several of the key informant interviewees are referenced below:

    - Richard Michael, a retired male pharmacist living in Fort Dodge, Iowa. Richard serves as the Medicare consumer advocate representative on the UnityPoint Accountable Care

[56] The interviews were facilitated by a member of the UnityPoint Health Government & External Affairs department. Each interview lasted for approximately 50 minutes. Each discussion was recorded and quotes included in this proposal are taken verbatim.

Board of Managers and is also a Medicare plan selection counselor for the State of Iowa's Senior Health Insurance Information Program (SHIIP).

- "Joan"[57] , a retired female health care professional living in the Greater Des Moines Area, Iowa. Joan has previous professional experience in direct patient care and case & utilization management for health insurance companies, and serves as a primary caregiver to her parent.

The interviews were designed to gather both professional and personal input on the Medicare program, including Original Medicare (Parts A and B), Medicare Advantage (Part C), Medicare Supplement Plans, and Prescription Drug Plans (Part D). Topics of discussion focused on a set of closed- and open-questions that were used to determine specific factors that play in making Medicare plan selection decisions, such as cost, access and benefit plan design, among others.

Strength of the Key Informant Interviews: Given the time constraints under which this proposal was developed and formalized for submission to and consideration by CMS, a key informant interview methodology was used for initial Medicare beneficiary findings. The key informant interview methodology is inherently different from other qualitative and quantitative research methods because it relies on subject matter expertise from the interviewees. Further, this particular methodology refers to "the person with whom an interview about a particular organization, social program, problem or interest group is conducted" and has broad, relevant personal and professional experience to serve as a proxy for a defined organization or group of individuals."[58] While the selection of key informant interviewees was non-random and are not statistically significant, the input gathered from each is significant as it represents a general culmination of professional and personal experiences with the Medicare program.

A ~~formal request to CMS for a~~ larger-scale, statistically significant survey of the Medicare beneficiary population outlined in this document will be conducted ~~submitted for consideration~~ following formal approval of this proposal.

Key Findings from Key Informant Interviews: The information gathered through the interviews confirmed numerous propositions put forth in this proposal and supported by industry literature. **Iowa beneficiaries are looking for an intimate relationship with their providers and would like their providers to assist them in determining what Medicare coverage choices are best for them; rural access to care is a challenge and efforts need to be made to extend coverage in rural markets; and beneficiaries want coverage that suits their needs.**

- **The term "network" is not well understood by Medicare beneficiaries.** Both key interviewees discussed at length the confusion they have seen among Medicare beneficiaries specific to physician/provider and health care facility networks. "When I am working with Medicare folks who are seeking SHIIP's help to select a Medicare Supplement or Part D plan, one of the biggest

[57] "Joan" is a pseudonym that was used as the interviewee was promised that certain identifying information such as first and last name would be protected.

[58] Lavrakas, P. J. (2008). Encyclopedia of Survey Research Methods. Thousand Oaks, CA: Sage Publications, Inc. http://dx.doi.org/10.4135/9781412963947.n260

things I hear is, 'what do you mean by that?' when I talk about networks," says Richard Michael. Both interviewees commented that network needs for Medicare beneficiaries depend on a variety of factors, including place of residence and geographic location and those living in rural areas that may have limited access to network providers in their immediate or surrounding geographic area.

- **Medicare beneficiaries generally make decisions on enrolling in a Supplement or MA plan through recommendations from friends, family members and/or SHIIP or other similar "Medicare enrollment experts".** Both interviewees described personal and professional experiences in how they or other members of their family or Medicare beneficiaries they provided guidance to ultimately indicated they selected a particular Medicare plan. "I hear the talk from folks in our SHIIP office…they are constantly asking their friend down the hall in assisted living, a next-door neighbor or a friend, 'hey, what plan do you have? Why'd you pick that plan?' They talk about if they receive a bill from the hospital or not [if it's covered by a monthly premium or the plan requires deductible, co-pay or other out-of-pocket costs]," commented Richard Michael. Joan indicated that, as a caregiver her mother relies on her expertise to select Medicare plans that meet her mother's care and financial needs and that, "when looking at Part D options [for myself], every year I log on to Medicare to review all of the available plans so that I can decide which are most cost-effective. The plans change every year…plans change, the prescription drugs that are covered change."

- **Currently in Iowa, MA plans may be more attractive to Medicare beneficiaries living in urban areas and/or those who are not considered "snowbird" or regular travelers.** "The Medicare patients who live in urban areas tend to like the Medicare Advantage plans better because they have more teams of specialists, more pharmacy options close to home," commented Richard Michael. In addition, Michael provided several examples of when Medicare beneficiaries he has worked with who live in rural areas with limited access to specialty or sub-specialty services would require greater distances to travel to urban areas for care. The expanded use of telehealth as an opportunity to make MA plans more attractive in rural areas was mentioned during the interviews. Specific to "snowbird" or regular travelers, Joan commented that, ""What people would like to see in Medicare Advantage plans is -- so, our son lives in Chicago. So, if we're in Chicago for the weekend and one of us [married couple receiving Medicare] gets sick, what criteria would there be so if we went to an E.R. or an urgent care that it would be covered?" Further, MA plans that offer comprehensive out-of-network coverage of emergent and urgent care would be an important component to include in benefit plan design.

- **MA plans with a consistent range of access to primary and specialty care is an attractive plan option for Medicare beneficiaries.** Interviewees commented about the desire from Medicare beneficiaries to have access to an MA plan that would include a comprehensive network of primary and specialty care physicians, providers and facilities that would allow for assurances that a variety of care and services could be available and accessed in-network. Additionally, both interviewees explained the general consensus from Medicare beneficiaries they have worked with about the importance of MA plans offering consistent access to their primary care provider from year-to-year.

- **New Medicare beneficiaries or those currently receiving coverage under Supplement Plans would be more likely to switch to a MA plan with "perks" such as dental or vision coverage, or partial coverage of hearing aids, along with offering transportation assistance.** When asked about benefits that they would personally like to see, or have heard from other Medicare beneficiaries that they would like included in a MA plan, both interviewees discussed dental, vision and hearing aid coverage as key differentiators for plan selection. Joan said, "I would be very interested in Medicare Advantage plans that have the offerings I am looking for. I believe that some of the Advantage plans pay for hearing aids, and I think there is typically a lower premium. I think some plans pay for some dental, too. Those things would play in to our decision to pick a plan." In addition, assistance with transportation to and from medical appointments and for regular activities such as shopping would be a helpful benefit.

- **MA plans that can offer "seamless, one-stop shopping" in terms of payment of premiums, deductibles, co-payments and out-of-pocket costs would serve as a key differentiator.** When asked how Medicare beneficiaries would feel about having to make only one payment to cover premiums, Part A, Part B, Part D and co-pays, Joan said, "I think only having to make one payment to cover premiums would be great. It would be convenient, like one-stop-shopping." Richard Michael explained that, when compared to MA plans, Medicare beneficiaries in Iowa with Medicare Supplement F Plans "may have larger out-of-pocket premiums but generally do not have any deductibles, co-pays or limited networks – something they like. Everything is seamless." Additionally, both interviewees expressed that MA plans that can more easily simplify the billing process for Medicare patients would be ideal. "Patients don't need to worry about interpreting a bill because they simply don't have one," commented Michael.

- **Medicare beneficiaries would like to assistance from their providers in understanding Medicare plan option basics.**

- **Medicare beneficiaries may differ in terms of reasons that they would or would not change their Medicare plan, but this may change with the elimination of Medicare Supplement Plan F in 2020.**[59] The interviewees explained that, in general, their experience is that once Medicare beneficiaries enroll in a particular Supplement Plan, they tend to stay with the plan for the duration of their lives. However, one interviewee commented that with the elimination of Medicare Supplement Plan F as an option for new Medicare beneficiaries enrolling on or after the year 2020, MA plans in Iowa may become more attractive. Joan explained that, "it wouldn't bother me a bit to change my Medicare coverage, if I thought it was as good or better coverage for relatively the same cost. I mean, I never hesitate every year to change our Part D coverage [to fit our needs] … because of what I did for so many years [professional roles as a case manager at an insurance company, nurse and utilization review coordinator] I feel like I have a pretty good understanding [of how to select Medicare coverage]."

[59] Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) changed the law on various aspects of health care, including some Medicare Supplement plans. On or after January 1, 2020, a Medicare Supplement policy that provides coverage of the Part B deductible may not be sold or issued to a newly eligible Medicare beneficiary. This includes Supplement Plan F.

2. **Provider Insights**: Under the proposed Model, providers are not a unit of service, but are engaged owners. When providers are expected to serve both their patients and the financial interest of their organization, their engagement grows and necessitates involvement in leadership.[60] "Effective engagement of providers under the ACO model [or this proposed provider integrated MA plan] is critical to motivating the care transformations necessary to improve outcomes, and it also influences beneficiaries' acceptance of this model of care."[61]

   In addition to initiating an understanding and respect for quality patient care, the differentiator with value-based provider models is the emphasis on population health and total cost of care. Providers are no longer siloed in their own specialty or site of service. The emphasis has shifted to efficient use of referral patterns and partnering more closely with specialists, hospitals, diagnostic, and post-acute services that provide evidence-based high-value care and that communicate and coordinate effectively.[62] Indicators of success now include interventions that facilitate care coordination and provide more comprehensive care, such as use of care coordinators, behavioral therapists, or support staff to facilitate gaps in care.[63]

3. **Marketing and Communications Strategy**: The MA Plus plan could adapt current MA Marketing and Communications strategies and materials to this Model in partnership with CMS. The most immediate goal of this strategy is to provide comprehensive outreach to beneficiaries on an accelerated timeframe associated with the 2019 Annual Election Period. To provide a backdrop, we have bulleted below some key strategies / tactics, market insights and timeframe considerations.

   Medicare ACO patients would be enrolled in the MA Plus plan for 2019 through a new attribution-based enrollment model with CMS. All aligned Medicare ACO beneficiaries would receive information on the affiliated MA Plus plan, and the information they need to opt out, timeline, and what actions to take (if any). All beneficiaries who receive this communication would have the option to "opt out" of the MA Plus plan and remain in the ACO.

   Specific strategies and tactics include:

   - Creating a guiding, partnering experience for beneficiaries that is proactive and transparent
   - Maintaining a MA Plus plan call center with Model knowledge to support beneficiaries
   - Being a trusted expert on how to make decisions on Medicare options and the differences in types of plans
   - Building a base of internal and external ambassadors
   - Mailing communications to beneficiaries (three communications)

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[60] Colla, *op. cit.*

[61] Belliveau, J. *Provider Engagement Key to Accountable Care Organization Success*, RevCycle Intelligence, October 17, 2016, https://revcycleintelligence.com/news/provider-engagement-key-to-accountable-care-organization-success; See also, Akosa, op. cit., The level of physician engagement could directly affect the improved access and quality and reduced cost.

[62] Mostashari, F., Sanhavi, D., and McClellan, M. *Health Reform and Physician-Led Accountable Care: The Paradox of Primary Care Leadership*. JAMA Network, May 14, 2014, https://jamanetwork.com/journals/jama/fullarticle/1861359

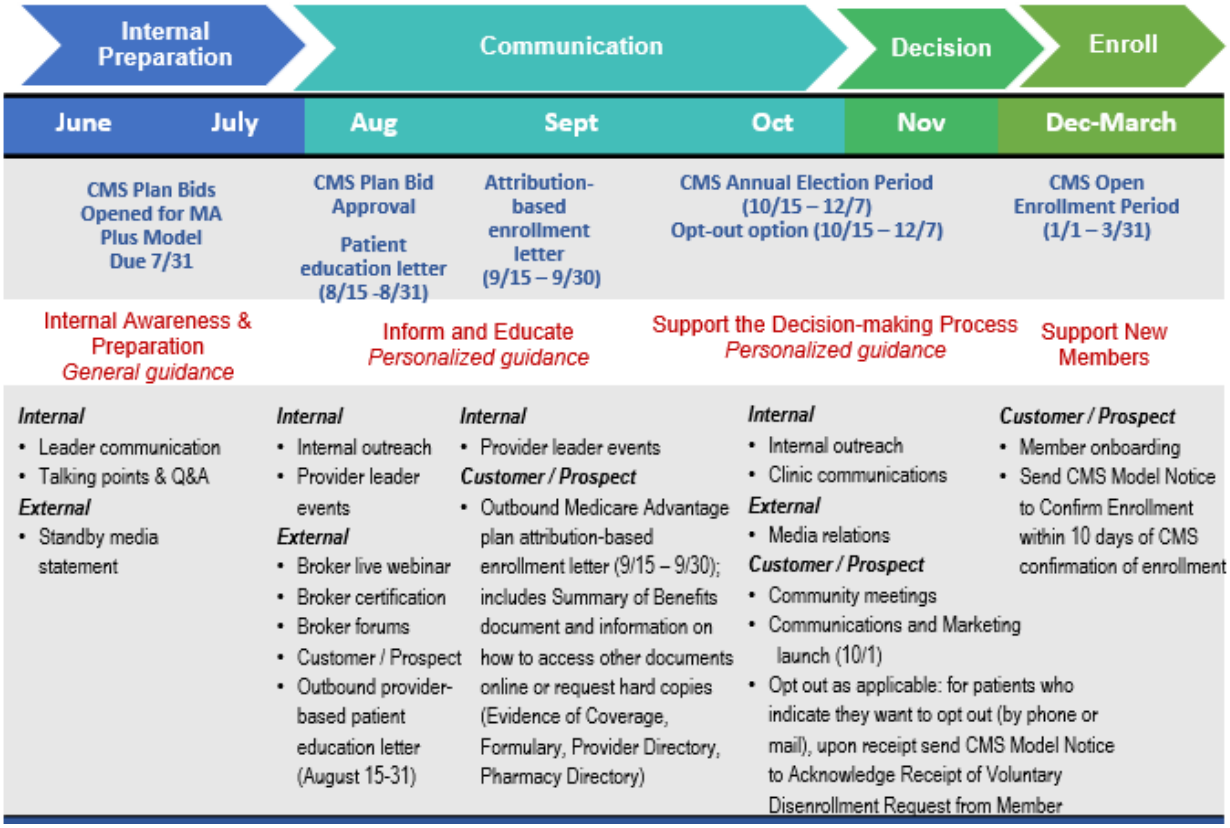
[63] Marsteller, J., Young, H., Fakeye, O., Hsu, Y., McGuire, M, Poffenroth, M., and Berkowitz, S. Early Provider Perspectives within an Accountable Care Organization. The American Journal of Accountable Care, September 14, 2016. http://www.ajmc.com/journals/ajac/2016/2016-vol4-n3/early-provider-perspectives-within-an-accountable-care-organization?p=1

- Provider-based patient education letter
- MA Plus plan attribution-based enrollment letter (sample content was described in *III.C.2. Enrollment and Opt Out Process*)
- Opt-out confirmation letter or new member information

All aspects of the beneficiary outreach take into consideration special market insights that are a function of the MA Plus Model. First, beneficiaries will not be familiar with a MA Plus plan or may not understand the benefits they receive by being attributed to an ACO. Second, we would need to explain if they opt out of the MA Plus plan that they would continue to remain attributed to the ACO. And third, we would need to carefully explain the differences among the MA Plus plan, MA plans, Original Medicare and Medicare Supplement options.

Our suggested communications timeline is provided in *Exhibit 03* below. While Traditional MA requires a 45-day CMS review period for some beneficiary communications, such as summary of benefit documents and website go lives, this Model's expedited start date would benefit from the CMS "file and use" process and its 5-day timeframe.

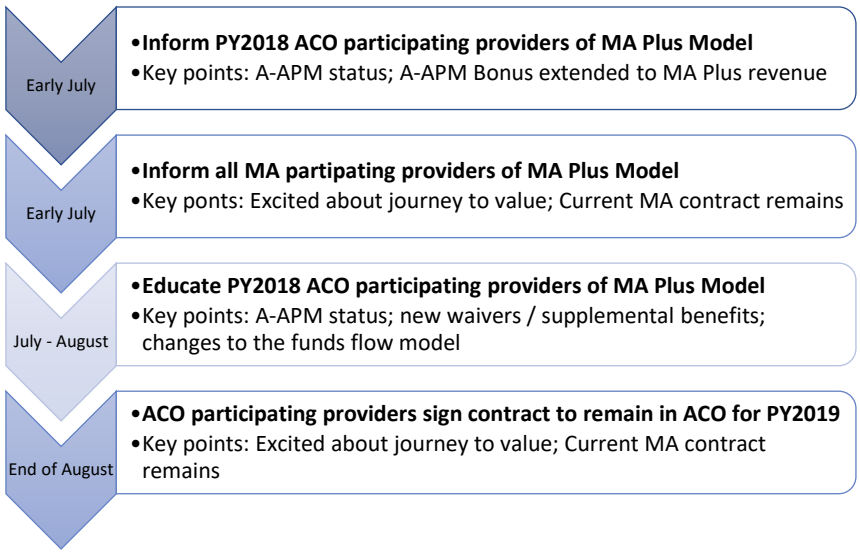
Exhibit 03



4. **<u>Network Outreach</u>**: As a provider integrated MA model, providers and their engagement are key to the success of care delivery and model outcomes. Messaging needs to occur early and often and include platforms that are interactive. *Exhibit 04* provides an accelerated timeframe that accommodates the 2019 Annual Election Period. For MA Plus plans, messaging would be incorporated during the MA contract negotiations. For the ACO, messaging would coincide with the submission of the provider list(s). For ACOs with preferred providers, the ACO would tailor

messaging to those providers accordingly to their list submission timeframes. As ACOs are a recent development in the healthcare landscape, ACOs have a wealth of provider outreach materials describing the ACO and their underlying Medicare contract obligations. These materials will be adapted to the MA Plus Model to facilitate provider understanding and engagement.

Exhibit 04



E. Service Area

1. **Network Adequacy Standards**: CMS has established quantitative minimum time and distance requirements and minimum provider ratios to assure access to care for MA Plan beneficiaries.[64] The MA Plus Model would test alternative means to meet access requirements to care for MA Plus beneficiaries. The quantitative time and distance standards could be supplemented through access sources that include "innovations in care delivery (telemedicine, centers of excellence)."[65] Both telehealth and Centers of Excellence are common practices for service delivery within ACOs. These alternatives could increase healthcare options to beneficiaries in areas previously unserved or underserved by MA plans. For instance, 30% of Next Generation ACO beneficiaries attributed to UnityPoint Accountable Care reside in counties that do not meet network adequacy standards. We offer these alternative sources of access for CMS' consideration.

    a. *Expanded Use of Remote Access Technologies*: Many regions of the country struggle with shortages of both primary care and specialty physicians affecting underserved communities.[66] With an initial emphasis on rural workforce issues, policymakers have emphasized telehealth

[64] CMS, Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance (Last updated: February 20, 2018) https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/2018-Network-Adequacy-Guidance.pdf

[65] *Id.*

[66] Ahn, Corlette, and Lucia. *Can Telemedicine Help Address Concerns with Network Adequacy? Opportunities and Challenges in Six States*. Robert Wood Johnson Foundation. April 2016. http://www.urban.org/sites/default/files/publication/79551/2000736-Can-Telemedicine-Help-Address-Concerns-with-Network-Adequacy-Opportunities-and-Challenges-in-Six-States.pdf

as a viable option.[67] As telehealth continues to expand in popularity through use of virtual visits, remote consultation by specialists, monitoring devices, and store and forward technology, reimbursement for these services is being demanded. Starting in 2015, state regulators identified telehealth as a bridge to access for network adequacy.[68] For CY 2018, CMS followed suit and established a network adequacy exception process for rural areas (i.e. rural or micro county types) by permitting the use telehealth or a mobile provider.[69]

We request that this Model test expanded flexibility afforded by the current telehealth exception process to encompass all county types (including Metro and Large Metro county types), regardless of population and/or density. By expanding the footprint of MA, this directly tests the future sustainability of the Medicare program by making an MA Plus plan an available option for more beneficiaries and allowing more providers to participate. This change would not impact the definition of telehealth services as defined by the Physician Fee Schedule and annual updates[70] nor alter the current exception process[71] in Section 5.3.3. of the Network Adequacy Guidance. By aligning expanded telehealth coverage to network adequacy requirements, the Model will create a service delivery environment that better encourages telehealth utilization, which will enhance the opportunity to test its use (i.e. how and where) and determine its impact on access to care and member satisfaction with telehealth services. Current MA CAHPS patient survey measures could be included in this analysis – four measures in MA Domain 3 (Ease of Getting Needed Care and Seeing Specialists; Getting Appointments and Care Quickly; Coordination of Members' Health Care Services; NS Member's Rating of Health Care Quality). The telehealth utilization data from MA Plus Model

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[67] "Congress should allow greater use of telemedicine and remove regulations that reduce competition." Senator Bill Cassidy, *op. cit.*; "do continue to allow telehealth practice to extend the reach of our in-person providers" Thompson, S. Testimony before the United States Senate Committee on Finance Hearing: Rural Health Care in America: Challenges and Opportunities, May 24, 2018, https://www.finance.senate.gov/imo/media/doc/24MAY2018ThompsonSTMNT.pdf

[68] Recently, the National Association of Insurance Commissioners (NAIC) issued a revised model law for network adequacy. National Association of Insurance Commissioners Health Benefit Plan Network Access and Adequacy Model Act, MDL-74. http://www.naic.org/store/free/MDL-74.pdf. States have started to adopt a similar approach. Colorado allows telehealth to meet network adequacy requirements for specialists in both rural and urban settings. Colorado Rev. Stat. §10-16-704, telemedicine provisions not effective until January 1, 2017 and Colorado Dept. of Regulatory Agencies, Div. of Insur. Bulletin No. B-4.90. California, Hawaii, and Illinois laws also authorize telehealth to meet network adequacy throughout their states. California Assembly Bill 205 permits telehealth services to be considered as an alternative access standard https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB205; Hawaii Senate Bill 387 requires health carriers' access plans to describe how telehealth and other technology may be used to meet network access standards https://www.capitol.hawaii.gov/Archives/measure_indiv_Archives.aspx?billtype=SB&billnumber=387&year=2017; Illinois House Bill requires insurers in their network plan to describe how telehealth and telemedicine may be used to partially meet network adequacy standards - https://trackbill.com/bill/illinois-house-bill-311-network-adequacy-transparency/1333084/ Neither the NAIC revised model nor the newly enacted state laws are restricted to rural areas.

[69] 5.3.3 Expanded Flexibility for Rural Areas, Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance (Last updated: February 20, 2018) https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/2018-Network-Adequacy-Guidance.pdf

[70] Section 1834(m)(4)(F) of the Social Security Act - "telehealth service" is defined as professional consultations, office visits, and office psychiatry services, and any additional service specified by the Secretary in an annual update.

[71] Conclusive evidence must be provided to demonstrate that there is an insufficient supply of providers/facilities and contracted network furnishes 90% of enrollees by county with adequate access that is consistent or better than original Medicare pattern of care.

could also enable CMS to develop modernized time and distance requirements within a digital landscape, since CMS bases network time and distance from existing utilization patterns by specialty.

b. *Flexibility for Service Line Consolidations and Centers of Excellence*: Time and distance requirements are relevant for in-person services, including procedures, facilities and facility-based programs, and a telehealth exception cannot be a substitute for these services. While access is important, we would suggest that CMS consider embedding flexibilities within the time and distance requirements to support quality access. In particular, current requirements may be a barrier when healthcare communities are pursuing service line and Centers of Excellence (COE) models that optimize quality at fewer locations to promote value and ensure sustainability of specialty programs. As efficiencies are gained and quality prioritized, Medicare beneficiaries should share in the rewards of improved quality, reliability, and better financial sustainability.

We request that CMS implement a quality exception to the current time and distance requirements. This would entail meeting network adequacy via service lines or COEs outside current time and distance parameters. The exception process would require evidence of COE or service line excellence status as well as beneficiary protections in the form of corresponding travel benefits for patients to travel to the centralized location for care. Rather than setting strict time and distance standards for this exception, we would urge CMS to consider allowing the applicant to describe the heightened quality of care and explain why the distance should be considered reasonable. This exception is especially pertinent for this Model which is based on a patient's relationship with their providers. The quality of care exception to network adequacy allows the MA Plus Model to test its impact on access, quality and beneficiary satisfaction. It also supports a provider integrated MA Model by enabling providers to become more meaningfully engaged in cost accountability and heightened quality.

F. Payment Mechanisms

1. **Payment, Benchmark Calculation, and Risk Adjustment**: The MA Plus Model would follow the general MA payment structure with a monthly capitated payment based on enrollment. Specific services, benchmarks and pricing result from the MA application and bid review and executed MA contract. The Model would also follow the CMS-HCC (Hierarchical Condition Category) model to risk adjust enrollees in order to predict their healthcare spend.

Accurate risk scores help to ensure that beneficiaries receive the appropriate care management and related services they need based on their condition. To hit the ground running, MA Plus plans would need to have accurate risk scores for its enrolled members readily available. In many cases, a new Medicare beneficiary has no medical claims history on which to base an HCC score. This is true for beneficiaries new to Medicare as a part of an ACO as well as beneficiaries new to MA upon aging-in or when a beneficiary leaves Original Medicare and enrolls in MA. In either event, the ACO or MA plan is at risk for a new beneficiary without a risk score. With attribution-based enrollment, we would request that CMS allow a bid adjustment process so that the MA Plus plan payment would include new enrollees under attribution-based enrollment. The bid adjustment

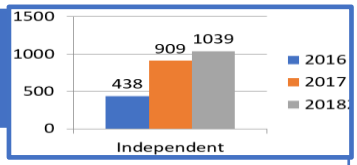
would be calculated by CMS using ACO claims data from the ACO for the newly enrolled MA Plus Plan members.

Fundamental to the risk scores is the related issue of accuracy and timeliness of patient information or data. HCC Code capture is critical to population health efforts in value-based risk-bearing models. While ACO models and MA plans account for risk adjustment under different methodologies, both rely on risk coding data to support robust analytics and care improvement. The MA Plus Plan should be allowed to use ACO claims data as a business associate via the existing CMS-ACO Data Use Agreement to ensure that claims data can continue to be used to support population health efforts and that care management efforts continue uninterrupted. We would request that CMS mandate that the MA Plus plan share full CMS claims data with an ACO contracted in a risk sharing arrangement in a fashion similar to how CMS shares data through the ACO program.

2. **Advanced Alternative Payment Model Status**: MARCA established criteria for A-APM status.[72] As providers become responsible for heightened economic risk under an A-APM, these arrangements lead to lower Medicare costs as beneficiaries increasingly receive services from these providers. To incentivize providers to participate in an A-APM, the Quality Payment Program (QPP) reduces the quality reporting burden and provides a 5% participation bonus on all Part B revenues. This A-APM bonus plays a key role in attracting participation as well as helping progressive and creative ACOs to develop risk sharing models that fit the marketplace. This has been critical for supporting the move from volume to value (See *Exhibit 05* – A-APM Status and Specialist Movement to Value).

Exhibit 05

A-APM Status and Specialist Movement to Value



As a Next Generation ACO, UnityPoint Accountable Care (UAC) is eligible for A-APM status and did achieve this status for the first MACRA performance period. Independent providers comprise 33% of our NGACO contract. From 2015 to 2016, independent providers, including specialists with attribution, more than doubled. Key specialists included oncology, psychology, gastroenterology, orthopedics, and cardiology.

Under current QPP rules, when an ACO's attributed lives would be converted to an MA Plus plan, the corresponding 5% bonus would be lost as the Part B revenues shift to Part C revenue. Further, the lives that remain in an ACO may not be adequate to allow the ACO's participating providers to A-APM thresholds. The MA Plus Model is a model that derives care delivery innovations from its providers. The past participation of such providers should be recognized through the continuation of the A-APM bonus for those willing to transition to the MA Plus Model.

For the CY 2019 All-Payer A-APM determination, we request that CMS re-open the health plan

[72] 42 CFR 414.1415 – Advanced APM criteria. Criteria include: 1. Require participants to use certified electronic health record technology (CEHRT); 2. Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS); and 3. Either: (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses.

application process to enable potential MA Plus plan applicants to submit their payer initiated form.[73] This will enable MA Plus plan participation to count for A-APM revenue and patient thresholds. In addition, we propose that CMS permit the ACO affiliated with the MA Plus plan to count their MA Plus patients and revenues toward meeting Medicare-only A-APM threshold requirements. The 5% A-APM bonus could be calculated on Part B revenues for Original Medicare claims as well as the MA Plus plan claims from ACO lives that are enrolled in the MA Plus plan. In support of this calculation, the MA Plus plan could be required to submit claims data to CMS. Such bonuses could be made available using the MACRA timeframe and should be paid directly to affiliated ACO providers within the MA Plus plan.

3. **Quality Performance Reimbursement**: MA quality performance is captured through the Star measures and rating system. In 2017, 66 percent of MA enrollees chose plans with 4 or more stars[74]; whereas, 41% of MA Plans had at least a 4-star rating.[75] Beneficiaries are disproportionately enrolled in high-quality MA Plans. New MA plans receive a default 3-star rating for their first 3 years, often making them less attractive in the marketplace; however, new plans also receive a 3.5% Quality Bonus Payment, subject to benchmark caps. In many cases, this start-up period can be longer due to an inability of the MA Plan to reach enrollment levels necessary to be rated above 3 stars. We request that CMS grant special consideration to MA Plus plans with heightened quality scores attributed to the affiliated ACO so they can be competitively and accurately branded in the marketplace. Although not identical, the similar domains and overall number of ACO quality measures and MA star measures would support that high ACO performance should be similarly treated and transferrable using an interim scoring approach.

   Supplemental Scoring: The MA Plus Model should receive transitional supplemental scoring under the MA star measures for Model Participants with members enrolled from affiliated ACOs with a history of high quality performance. Specifically, if the affiliated ACO has demonstrated high scoring for its overall Quality Score, the MA Plus plan should be deemed a 4-star plan for the first two years of the Model. After the initial two-year period, the MA Plus plan should revert to standard star scoring based on its performance on the MA star measures. MA Plus plans not affiliated with an ACO earning high quality scores should receive a 3-star rating like new traditional MA plans.

G. Quality Measures and Star Ratings

1. **Quality Measures**: The ACO quality measure set and the MA star measure set are similar (See *Exhibit 06*) and both use an update process which involves public notice and input; however, there are notable differences between the measurement sets. The ACO measure set contains more

[73] Currently health plan payers may submit requests though HPMS with a deadline of June 4, 2018. QPP, *A Guide to Submitting Medicare Health Plan Requests for Other Payer Advanced APM Determinations*,

[74] Jacobson, G., Damico, A., and Neuman, T. *Medicare Advantage 2017 Spotlight: Enrollment Market Update*. The Henry J. Kaiser Family Foundation. June 6, 2017. https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/

[75] Jacobson, G., Damico, A., Neuman, T. and Gold, M. *Issue Brief: Medicare Advantage Plans in 2017: Short-term Outlook is Stable*. The Henry J. Kaiser Family Foundation. December 2016. http://files.kff.org/attachment/Issue-Bried-Medicare-Advantage-Plans-in-2017

individual measures in domains that relate to patient health status than MA (Managing Chronic Conditions and Staying Healthy). As for patient/member experience, the MA measure set contains more individual measures than the ACO, but the focus of the health plan measures is largely administrative or compliance related and do not focus on satisfaction with the patient's provider(s). For provider organizations, the current star measures may not adequately capture their service delivery model and patient satisfaction.[76]

Exhibit 06

Domains		Measures	
MA	**NGACO**	**MA**	**NGACO**
Managing Chronic (Long Term) Conditions (13)	At Risk Population (5)	C08-SNP Care Management C09-Care for Older Adults – Medication Review C10-Care for Older Adults – Functional Status Assessment C11-Care for Older Adults – Pain Assessment C12-Osteoporosis Management in Women who had a Fracture C13-Diabetes Care – Eye Exam C14-Diabetes Care – Kidney Disease Monitoring C15-Diabetes Care – Blood Sugar Controlled (3) C16-Controlling Blood Pressure (3) C17-Rheumatoid Arthritis Management C19-Improving Bladder Control C20-Medication Reconciliation Post-discharge C21-Plan All-Cause Readmissions (3)	ACO40-Depression Remission at Twelve Months ACO27*-Diabetes Mellitus: Hemoglobin A1c Poor Control ACO41*-Diabetes: Eye Exam ACO28-Hypertension (HTN): Controlling High Blood Pressure ACO30-Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
	Care Coordination / Patient Safety (10)		ACO8-Risk-Standardized, All Condition Readmission ACO35-Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) ACO36-All-Cause Unplanned Admissions for Patients with Diabetes ACO37-All-Cause Unplanned Admissions for Patients with Heart Failure ACO38-All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions ACO43-Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91) ACO11-Use of Certified EHR Technology ACO12-Medication Reconciliation Post-Discharge ACO13-Falls: Screening for Future Fall Risk ACO44-Use of Imaging Studies for Low Back Pain
Member Experience with Health Plan (6)	Patient/Caregiver Experience (8)	C22-Getting Needed Care (1.5) C23-Getting Appointments and Care Quickly (1.5) C24-Customer Service (1.5) C25-Rating of Health Care Quality (1.5) C26-Rating of Health Plan (1.5) C27-Care Coordination (1.5)	ACO1-CAHPS: Getting Timely Care, Appointments, and Information ACO2-CAHPS: How Well Your Providers Communicate ACO3-CAHPS: Patients' Rating of Provider ACO4-CAHPS: Access to Specialists ACO5-CAHPS: Health Promotion and Education ACO6-CAHPS: Shared Decision Making ACO7-CAHPS: Health Status/Functional Status ACO34-CAHPS: Stewardship of Patient Resources
Member Complaints and Changes in the Health Plan's Performance (4)		C28-Complaints about the Health Plan (1.5) C29-Members Choosing to Leave the Plan (1.5) C30-Beneficiary Access and Performance Problems (1.5) C31-Health Plan Quality Improvement (5)	
Health Plan Customer Service (3)		C32-Plan Makes Timely Decisions about Appeals (1.5) C33-Reviewing Appeals Decisions (1.5) C34-Call Center – Foreign Language Interpreter and TTY Availability (1.5)	
Staying Healthy: Screenings, Tests and Vaccines (7)	Preventive Health (8)	C01-Breast Cancer Screening C02-Colorectal Cancer Screening C03-Annual Flu Vaccine C04-Improving or Maintaining Physical Health (3) C05-Improving or Maintaining Mental Health (3) C06-Monitoring Physical Activity C07-Adult BMI Assessment	ACO14-Preventive Care and Screening: Influenza Immunization ACO15-Pneumonia Vaccination Status for Older Adults ACO16-Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up ACO17-Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention ACO18-Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan ACO19-Colorectal Cancer Screening ACO20-Breast Cancer Screening ACO42-Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

For MA Measures, weight = 1.0 unless otherwise denoted in parentheses. For NGACO Measure, "*" denotes a diabetes composite measure.

2. **<u>Quality Reporting</u>**: Participants in this Model would be subject to the MA star measurement and rating system. As such, quality would be reported via HPMS by the MA Plus plan. While MA star measures would be reported for individual plan compliance, payment and performance improvement purposes, these measures could also be captured for Model evaluation to compare Model Participants with each other and to other traditional MA plans.

   This Model also presents an opportunity to evaluate whether a provider integrated MA Plus plan is uniquely positioned to warrant the inclusion of substitute measures within the current MA star measure set. This is not to suggest that the Model should be separately measured or contain

a laundry list of additional measures, but rather to consider whether some of the administrative measures related to plan functions should be substituted with shared decision-making measures. We would suggest that this Model in its evaluation compare MA star measures for the MA Plus plan to the ACO quality measures for affiliated Medicare ACO. These results may help to identify how to best measure and differentiate, as needed, this proposed Model and its Participant Plans from MA plans generally. The question being answered is whether the MA Plus Model should have differentiated quality measures due to its integrated provider structure. This analysis should also incorporate learnings from the CMS Meaningful Measures initiative[77] to streamline measures and make them meaningful to beneficiaries and less burdensome to providers.

3. **Quality Payment Program (QPP) Implications**: As referenced in the *III.F.2. Advanced Alternative Payment Model Status* narrative, we have requested that CMS re-open the form submission for the All-Payer Combination Option for A-APM determination to enable participation by clinicians in MA Plus plans for CY 2019. This would support providers in achieving A-APM status.

H. Program Compliance

1. **Program Requirements**: We suggest that MA Plus plans would be subject to the same compliance obligations of MA plans. The MA Plus Model would follow MA requirements related to its Compliance Plan and Compliance Officer. These requirements include First Tier, Downstream and Related Entities (FDR) oversight responsibilities, compliance trainings for staff and providers, and audit activities.

2. **Fraud and Abuse Waivers**: Under Section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of Sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out section 1115A with respect to testing Models described in section 1115A(b). For this Model and consistent with this standard, the Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act. We urge the Secretary to consider issuing such fraud and abuse waivers to permit participation and/or patient engagement incentives and activities similar to those issued for ACOs under the MSSP and extended to the Next Generation ACO Model.[78]

IV. ACO PROTECTIONS FOR MA PLUS MODEL PARTICIPATION

The bulk of the proposal thus far has addressed the transition of ACO beneficiaries to the MA Plus

[77] Link to Meaningful Measures Hub for additional information, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html

[78] For MSSP ACOs, waivers are to be approved by the ACO governance structure as authorized by CMS and the OIG pursuant to the "*Medicare Program; Final Waivers in Connection with the Shared Savings Program*" published on November 2, 2011. The extension of such rules and regulations to the Next Generation ACO Model is authorized in the "*Notice of Amended Waivers of Certain Fraud and Abuse Law in Connection with the Next Generation ACO Model*" issued December 29, 2016.

construct. This section speaks to the aligned ACOs and their sustainability, recognizing that some beneficiaries may elect to remain in Original Medicare. While the degree to which beneficiaries may elect to opt out or dis-enroll is unknown,[79] an aligned ACO is likely to experience a reduction in attributed beneficiaries. The scope of this reduction and the needs of those who remain may significantly alter ACO operations. For this reason, CMS should consider these ACO safeguards:

- *Minimum Beneficiary Count*: Currently, these minimum count requirements are bright line standards which are violated by just deviating slightly from these amounts. As proposed for the MA Plus plans, should the remaining beneficiary count dip below the minimum requirements for the relevant ACO program, CMS would not impose any penalties, including termination or probationary status, on the aligned ACO for low beneficiary count for the duration of the Model. Instead, low beneficiary count may be considered good cause for an aligned ACO to withdraw from the ACO program at their discretion, although such a withdrawal would not be mandated.

- *Minimum Savings Rate*: While the MSSP tracks differ on how to set the minimum savings rate, it is often related to the ACOs attributed population. In addition, MSSP two-sided risk tracks require that minimum savings rates be symmetrical to minimum loss rates. After enrollment to the MA Plus plan is finalized, CMS may consider reducing the risk corridor accordingly, including providing an asymmetrical corridor for shared loses.

- *Rebasing the Benchmark*: The benchmark methodology varies across ACO programs. Since it is probable that the ACO population pre- and post-MA enrollment may significantly change, CMS may want to consider recalculating the benchmark for the ACO using the remaining population.

- *Advance Payment Model*: MSSP ACOs had the option to apply for upfront or monthly payments from CMS to be used for ACO infrastructure investments. ACOs that received an advance payment are obligated to repay this payment over a term of years. A significant drop in the ACO beneficiary count may impact the ACOs ability to repay CMS. Participation in the Advance Payment Model should not be an obstacle to a potential MA Plus Participant. Instead for Advance Model Participants, CMS could recalculate the outstanding obligation based on the difference of attributed ACO lives prior to MA Plus participation and attributed lives post MA Plus enrollment. Basically, the outstanding obligation could be proportionally forgiven for those beneficiaries that enrolled in the MA Plus Plan.

- *Population Based Payment (PBP)*: This is a payment option available to Next Generation ACOs. The Next Generation ACO determines a percentage reduction to the base FFS payments of its Next Generation Participants and Preferred Providers for care supplied to Next Generation Performance Year-aligned beneficiaries. This arrangement must be memorialized annually

[79] For 13 states in financial alignment demonstration, opt out rate has averaged 40% for those passively enrolled and the opt out rate is positively correlated with higher risk scores. *An Update on CMS's financial alignment demonstration for dual-eligible beneficiaries*, Staff presentation to MedPAC by Eric Rollins, March 1, 2018. http://www.medpac.gov/docs/default-source/default-document-library/mar-2018---duals-demos---slides---final.pdf?sfvrsn=0

between the ACO and its Participants and/or Preferred Providers. CMS makes monthly payments to the ACO based on the projected total annual amount of the base FFS rates. Since it is probable that the ACO population pre- and post-MA enrollment may significantly change, CMS may want to consider recalculating the PBP using the newly aligned population.

- *Switching to a Lower Program Track*: The two-sided risk MSSPs (Tracks 1+, 2 and 3) are prohibited from switching to MSSP Track 1, which is the upside-only track. Should the ACOs have a drastic dip in population, CMS may want to permit the ACO the option to switch to a lower MSSP track, including Track 1. Given that a small population makes the ACO more susceptible to financial outliers and CMS should encourage providers to remain in value-based arrangements, this option is preferred to a forced withdrawal from ACOs and return to Original Medicare without any value-based arrangement (even if a upside only arrangement).

- *Option to Withdraw*: Exiting ACOs are required to complete the CMS settlement process. For an aligned ACO whose reduced attribution will not sustain the ACO, CMS could permit the ACO exit the Medicare ACO contract for cause and upon appropriate notice. This contract termination should not need to coincide with the end of a performance year. Aside from exhausting any future attribution-based enrollment pool, such termination should not impact the MA Plus Model.

V. CONCLUSION

We cannot over-emphasize the importance of the potential our proposal has to launch solutions to two of the most pertinent problems in healthcare today: the lack of clarity to millions of future Medicare beneficiaries in obtaining a Medicare coverage plan and lack of stability in providers' Medicare reimbursement over the next two years.

Beginning January 1, 2020, millions of seniors will enter the Medicare market for the first time, and Medicare Supplement Plans C and F plans will not be available. Many of these seniors will be attributed to ACOs. Our proposal would eliminate the need for seniors to face confusion due to these coverage eliminations and take the guess work out of their entry into the Medicare phase of their lives.

Providers across the country are feeling the strain of an unstable Medicare reimbursement environment. It has been mandated that providers move to greater levels of risk in 2019 to achieve top reimbursement levels, yet current models for risk-bearing are unworkable for most providers. Our Model provides a realistic glide path for providers to move from a Fee-For-Service model of reimbursement into the time tested model of capitation through integrated involvement in a Medicare Advantage plan.

Our proposal offers solutions to these problems, and does so while promoting beneficiary choice, a superior beneficiary experience and access to care pathways for rural regions of the country. We request you give our proposal the highest consideration, and look forward to meeting with you to discuss the proposal in more detail. Please contact Sabra Rosener, sabra.rosener@unitypoint.org, (515)205-1206, with questions/comments or to organize in-person meetings with our team.