



Advancing High Performance Health

One Prince Street
Alexandria, VA 22314-3318
☎ 703.838.0033
✉ 703.548.1890

April 24, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Verma:

On behalf of the AMGA we appreciate the opportunity to comment on April 3 “Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information.” Founded in 1950, AMGA represents more than 440 multi-specialty medical groups and integrated delivery systems representing roughly 177,000 physicians who care for one-in-three Americans. Several of our members offer provider-sponsored health plans in Medicare Advantage (MA). We have a substantial interest in improving innovative, high quality, patient-centered medical care that both improves patient outcomes and is spending efficient under the MA program and Medicare more generally.

In the April 3 announcement the Centers for Medicare and Medicaid Services (CMS) solicited MA stakeholders to submit regulatory reform recommendations related to “benefit design, operational or network composition flexibility, supporting the doctor-patient relationship in care delivery, and facilitating individual preferences.” CMS also asked for recommendations “regarding changes in the way plans are paid and monitored and measured” and “ideas regarding Stars and their alignment to quality of care in terms of measure inclusion and exclusion or timing of changes and the method of assessment.” CMS, in its accompanying fact sheet, solicited stakeholders to provide “feedback” that would “transform the MA and Part D program.”

Synchronizing Medicare

If CMS is interested in “transforming” MA, AMGA believes the agency should work to, using MedPAC's word, “synchronize” Medicare Advantage with the Medicare Fee For Service and the Medicare Shared Savings Program (MSSP).¹ Doing so would create a more spending efficient Medicare program in sum, reduce the substantial burden providers and patients presently face in understanding and navigating different regulatory rules for three programs and would mitigate the burden taxpayers currently face in financing an under-performing and spending inefficient Medicare program.

Compare, for example, MA with the MSSP or Accountable Care Organization (ACO) program. There are several key differences including:

- in the MA program beneficiaries choose to enroll, ACO beneficiaries are simply assigned;
- MA benchmarks are based on county spending in which MA beneficiaries reside, ACO benchmarks are established based on their assigned beneficiaries historical utilization;
- MA beneficiary risk adjustment scores can increase by diagnosis, ACO risk scores for continuously assigned beneficiaries cannot;
- MA plans can earn extra payments for comparatively high quality performance, ACOs cannot;
- MA plans, unlike ACOs, can provide beneficiaries with additional or supplemental benefits, have spending caps and typically offer Part D benefits; and,
- MA is administrative pricing and therefore cost neutral, ACOs are designed to score Medicare savings.

Because these programs are not on a level playing field, they cannot compete. The absence of competition, particularly in light of the fact MA plans are increasingly concentrated in both metropolitan and non-metropolitan counties or markets, causes the overall Medicare program in sum to under-perform.²

Because of program inequities and inefficiencies, in its June 2015 and again in its June 2016 reports to the Congress, MedPAC argued Medicare should set payment rules and premium designs that reward efficient providers or plans and encourage beneficiaries to choose care through the most efficient providers or plans.³ This is because, MedPAC's research found program spending varied from market to market. For example, slightly more than one-third of Medicare beneficiaries live in markets where premium costs varied by more than over \$100 per month.

MedPAC proposed three options to more efficiently price premiums. CMS could set beneficiary premiums based on national spending; set premiums based on a nationally set premium that buys the cheaper of a reference MA plan or FFS Medicare in each market; or, set a local spending-based premium that buys the cheaper of a reference MA plan or FFS Medicare in each market. Under all of these scenarios, MA's administratively set benchmarks would be eliminated and instead, as MedPAC noted, "competition between FFS spending [that includes MSSP spending] and MA plan bids would determine the reference point for the federal contribution and beneficiary premium." MA plans would compete not only against FFS but with each other.

MedPAC argued if payment rules – and incentives were, again, "synchronized" or "geared toward making each [program] more competitive," beneficiaries could choose a preferred plan or one that provided them the best value and competition would drive out inefficiencies or drive market share away from less efficient providers or plans. Setting beneficiary premiums in a competitive, more cost efficient manner would not only serve the beneficiary's interests, but in addition allow the Medicare program in turn to reduce its low-income subsidy spending.

Among other considerations, MedPAC recognized, and AMGA agrees, because the disruption premium reformulation would cause, implementation could be accomplished over several years, premium formulas could be weighted over a transition period, certain beneficiaries could be grandfathered and

accommodations would have to be made for dual-eligibles as in some instances pays for a portion of Medicare Part B premiums.

Currently there are three separate and distinct Medicare programs. For Medicare providers, including AMGA members, this reality creates significant administrative burden to fully participate in the Medicare program. As noted above, different beneficiary assignment, coverage, financial incentives, payment rules and quality measures all combine to compromise providers' ability to provide optimum beneficiary care. Though AMGA opposed the agency's decision to begin implementing Medicare Access and CHIP Reauthorization Act (MACRA) Merit-Based Incentive Payment System (MIPS) in 2017 as "pick your pace," we will recognize the learning curve associated with migrating from the Physician Quality Reporting System (PQRS) the Value-Based Payment Modifier Program (VM) and HIT Meaningful Use (MU). For beneficiaries, among other differences these three Medicare programs provide different health care benefits, cost beneficiaries different premiums, co-pays, deductibles and as well as different payment caps.

Beyond transforming the Medicare program by substantially increasing beneficiary spending efficiency and dramatically reducing provider administrative burden, synchronizing premiums would likely qualify MA providers to participate in the MACRA Alternative Payment Model (APM) pathway.

Improving Quality via Incentive Neutrality

Few would disagree the evidence in support of financially incenting providers is, at best, mixed. Despite PQRS's financial incentives, the provider community has been slow to participate. For example, in 2013 or six years after the program started, only half of eligible professionals were participating. Only approximately one-quarter of ACOs earn shared savings and those that have been successful had comparatively substantially higher financial benchmarks. Concerning bundles, while there have been successful BPCI participants it is unclear whether any savings will be more than offset by increased volume. In a synthesis of the evidence to date in primary care, Cochrane states, "is insufficient evidence to support or not support the use of financial incentives to improve the quality of primary health care."⁴

For these reasons AMGA recommends CMS consider incentive neutral policies. As Robert Berenson and Thomas Rice wrote in a 2015 Health Services Research article, "public policy can support clinicians' intrinsic motivation through approaches that support systematic feedback to clinicians and provide concrete opportunity to collaborate to improve care."⁵ The authors argue financial incentives, particularly if they are marginal, may be less important than embedded or intrinsic incentives in motivating providers to improve quality and reduce spending. Financial incentives also risk "teaching to the test" problems, can undermine professionalism and commitment to the patient. Intrinsic or implicit incentives that reinforce working in collaboration and provide for non-public comparative data have proven successful. For example, the authors note CMS' Partnership for Patients initiative between 2010 and 2013 reduced patient harm by 17 percent, prevented 50,000 deaths associated with HAIs and saved the Medicare program \$12 billion – all without financial incentives playing a substantial roll. The authors argued quality can be improved and spending reduced by "relying on professionals' intrinsic motivation and organizations' mission to improve care, accompanied by straightforward quality improvement methods to produce actionable, common sense steps." The authors concluded, "rather than having one provider pitted against another to distribute financial rewards and penalties, provision of technical assistance and encouraging quality-related

collaborations can lead to more-desired results.”

We thank CMS for consideration of our comments. Should you have questions please do not hesitate to contact AMGA's David Introcaso, Ph.D., Senior Director of Public Policy at (703) 842.0774 or at dintrocaso@amga.org.

Sincerely,



Chester A. Speed, J.D., LL.M
Vice President, Public Policy
AMGA

Endnotes

1. MedPAC, Report to the Congress (June 2014) at: http://www.medpac.gov/docs/default-source/reports/jun14_entirereport.pdf?sfvrsn=0.
2. David Introcaso, “The Need to Level the Playing Field Between Accountable Care Organizations and Medicare Advantage,” (December 9, 2015) at: <http://www.ajmc.com/journals/ajac/2015/2015-vol3-n4/the-need-to-level-the-playing-field-between-accountable-care-organizations-and-medicare-advantage#sthash.qFDNUzvW.dpuf> and David Introcaso, “Synchronizing Medicare Advantage And ACOs To Support The Secretary’s Quality And Value Payment Goals,” Health Affairs Blog (December 28, 2015) at: <http://healthaffairs.org/blog/2015/12/28/synchronizing-medicare-advantage-and-acos-to-support-the-secretarys-quality-and-value-payment-goals/>
3. MedPAC, Report to the Congress (June 2015) at: <http://www.medpac.gov/docs/default-source/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0> and MedPAC, Report to the Congress (June 2016) at: <http://www.medpac.gov/docs/default-source/reports/june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0>.
4. Cochrane, “The Effect of Financial Incentives on the Quality of Health Care Provided by Primary Care Physicians,” at: http://www.cochrane.org/CD008451/EPOC_the-effect-of-financial-incentives-on-the-quality-of-health-care-provided-by-primary-care-physicians
5. Robert A. Berenson and Thomas Rice, “Beyond Measurement and Reward: Methods of Motivating Quality Improvement and Accountability,” Health Services Research (December 2015) at: <https://www.ncbi.nlm.nih.gov/pubmed/26555346>.