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Mr. John R. Graham
Acting Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC, 20001

Dear Mr. Graham:

AMGA appreciates the opportunity to comment on the Request for Information (RFI) titled, “Promoting Healthcare Choice and Competition Across the United States,” announced by the Office of the Assistant Secretary for Planning and Evaluation (ASPE).

AMGA, founded in 1950, represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Our member medical groups participate in every Medicare silo: Medicare Fee for Service (FFS), the Medicare Shared Savings Program (MSSP) or Accountable Care Organizations (ACOs); numerous Center for Medicare and Medicaid Innovation (CMMI) demonstrations including every Advanced Alternative Payment Model (APM) under Medicare Access and CHIP Reauthorization Act (MACRA); the Medicare Advantage (MA) program, or Medicare Part C; and, the Medicare prescription drug benefit, or Medicare Part D. AMGA members are equally invested in the success of all these program silos. A significant portion of AMGA members also participate in the Medicaid program.

The RFI states “each HHS [Health and Human Services] agency is conducting thoughtful analysis of its significant existing regulations . . . to determine whether each rule advances or impedes HHS priorities of: empowering patients and promoting consumer choice.” The RFI states “limited healthcare competition” has “dampened competition and innovation,” “erected barriers to entry” and “allowed [for] excessive consolidation.” “Limited choice and competition across all healthcare markets,” the RFI states further, is expected to cause health spending to grow faster than the GDP by 1.2 percent between 2016 and to 2025. Consequently, HHS is “interested in public comments” concerning regulations that “discourage or prevent the development and operation of a healthcare system that provides high-quality care at affordable prices.” More specifically, HHS seeks comments on, among other related issues, Medicare regulations that “reduce or restrict competition and choice in healthcare markets” and “suggestions for policies and other solutions . . . to promote the development and operation of a more competitive healthcare system that provides high-quality care at affordable prices for the American people.”

AMGA thoroughly supports the Department Health and Human Services' (DHHS') interest in improving premium affordability, consumer choice, provider innovation, and market competition. To this end we make these two over-arching Medicare-related comments or recommendations: competing Medicare's siloed programs and simultaneously promulgating regulatory reforms that drive or increase value, or outcomes achieved relative to spending. We are confident these recommendations would improve beneficiary choice and premium affordability, spur innovation in the clinical practice setting, drive competition and address the RFI's additional concern regarding "excessive consolidation" and "abuses of market power."

Medicare's "Siloed" Programs Should Compete¹

Over the past two decades Medicare has evolved into three separate programs or payment systems: Fee-For-Service (FFS), sometimes termed traditional Medicare; Medicare Advantage (MA); and, the Medicare Shared Savings Program (MSSP), or Accountable Care Organizations (ACOs). Regulations governing these three programs differ substantially. For example, participating plans, physicians and other eligible clinicians are reimbursed and/or financially incented in different ways. Under MACRA (the Medicare Access and CHIP Reauthorization Act), FFS providers and some ACOs can earn an annual bonus that would increase their reimbursements by a certain percent. Under the MACRA APM pathway other, at risk ACOs can earn a percent of shared savings and potentially an additional Advanced APM five percent bonus based on their previous year's total Part B billing if they meet certain minimum billing and beneficiary thresholds. MA plans are incented via quality Stars and are potentially eligible for the same five percent MACRA bonus, although their financial benchmarks are calculated differently.

Because of this, the annual rule making process for the Centers for Medicare and Medicaid Services (CMS) has become for the agency an increasingly demanding exercise, while for providers it has become an increasingly time consuming as they try to keep current on which rules apply to which program. CMS, tasked with appropriately paying for care and quality for a diverse population of 56 million Medicare beneficiaries in a complex \$680 billion market, now publishes 17 annual FFS rules, rules for the ACO program, rules for MA, rules to implement MACRA's Quality Payment Program (QPP), and additional rules and/or sub-regulatory guidance for the agency's numerous payment demonstration models. Among other complications, as the number of ACO and other APM models grow, CMS must determine who to incent, how to do so, and how to distribute bonus payments. The agency needs to determine which beneficiaries in which program are eligible to participate in which demonstration and it must also financially account for overlap in instances when a beneficiary receives care from one payment model but also participates in a payment demonstration.

As for taxpayers, their interest in maximizing Medicare's value is largely left unaddressed. They are asked to ostensibly look the other way while financing what amounts to an under-performing and spending inefficient Medicare program.

Fielding three Medicare programs might make sense if they were designed to compete against one another. They do not. They exist in silos. Recognizing that these three programs or payment systems are different and inconsistent for no useful or constructive reason, the

1 David Introcaso, "Medicare's Programs Should Compete," Health Affairs Blog (June 15, 2017), at: <https://www.healthaffairs.org/doi/10.1377/hblog20170615.060627/full/>.

Medicare Payment and Advisory Commission (MedPAC), as ASPE is likely aware, has explored the idea of, using MedPAC's word, "synchronizing" Medicare policy across the three models. Specifically, this means aligning how these three programs are financially benchmarked, risk adjusted, and rewarded for quality performance.²

Beyond correcting for effect, MedPAC has also been concerned with improving overall program efficiency and equity or competition.³ Spending efficiency or program savings could be gained by synchronizing financial benchmarks in order to identify, by market (FFS, ACOs, or MA), which is most efficient. To achieve equity and competition, regardless of which program the beneficiary chooses MedPAC argues Medicare should pay on average the same on behalf of all beneficiaries.

In its 78 market simulation, MedPAC found none of these three models produced the lowest cost in all markets. ACOs were the low cost option in 31 markets, FFS in 28 markets, and MA plans in 19 markets. The variation in FFS versus the median MA bid could be \$100 or more per month in beneficiary premium payments in either direction. Therefore, if we assume Medicare is a neutral payer under competitive benchmarking, beneficiaries would have to pay a higher monthly premium to remain in the less cost-efficient program.

Unfortunately, beneficiaries do this to a substantial extent. Using its own data set of 1,000 markets, in 2016 MedPAC identified 51 markets where the median MA bid was \$100 or more higher than FFS spending. Nevertheless, more than one-third of beneficiaries living in those markets were enrolled in a MA plan. Conversely, in 123 markets where FFS spending was higher than the median MA bid by \$100 or more, nearly two-thirds of beneficiaries were enrolled in FFS. Overall, about one-third of both FFS and MA beneficiaries in markets included in MedPAC's data set were paying an additional \$50 to \$150 in premium costs per month to participate in the more expensive option.

MedPAC was not naïve to the disruption neutral payments or premium reformulation would cause. MedPAC considered mitigating the effect by implementing competitive pricing over several years. Premium formulas could be weighted over a transition period. Certain beneficiaries also could be grandfathered and accommodations for the dually eligible would have to be made. For example, any reform would need to account for instances in which Medicare pays for a portion of a dual-eligible beneficiary's Part B premiums.

MedPAC also recognized the essential or critical need to encourage or motivate beneficiaries to shop for the most efficient care. This process, however, is inherently difficult due to, among other factors, asymmetric information, numeracy limitations, and cognitive burden and impairment. These likely explain why one-third of beneficiaries, as noted above, pay higher premiums. According to MedPAC, while only two to three percent of MA beneficiaries switch to FFS annually, compared to upwards of 50 percent of state Marketplace enrollees,⁴ between 20

2 MedPAC, Report to the Congress (June 2014), see chapters one through three. At: http://www.medpac.gov/docs/default-source/reports/jun14_entirereport.pdf?sfvrsn=0.

3 See, for example, 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>.

4 Paul Shafer and Stacie Dusetzina, "Looking Ahead to 2018: Will a Shorter Open Enrollment Period

percent and 30 percent of MA beneficiaries switched to another MA plan when monthly premiums increased by \$20 or more.

MedPAC did not provide an estimate of the amount of savings competition would derive. However, Medicare beneficiaries would save \$6.5 billion per year if half of the approximately 11 million total beneficiaries in the 51 and 123 markets noted above switched to the less costly alternative.

MedPAC made no formal payment recommendations to the Congress concerning this work. Regardless, the commission's effort shows promise for several reasons. Assuming, as MedPAC does, neutral payments based on competing benchmarks would expose inefficiencies and drive market share away from the less efficient, Medicare's financial solvency would be extended. Being a neutral payer also aligns with the Congress's 2014 IMPACT Act that requires post-acute care payments be spending neutral.

Having FFS, ACOs and MA compete would align with CMS' goal to pay for value at least to the extent the agency stops paying the costs of lost or missed opportunities. Neutral payment would enable the agency to achieve comparable business cases. Presently, ACOs and MA do not perform on a level playing field. However, CMS has recently taken steps to calculate ACO benchmarks using regional spending that is akin to MA benchmarking. Medicare Advantage is exactly that. Unlike ACOs, MA enjoys an unrestricted share of savings, is less incented to keep high cost enrollees and has enrollment, risk adjustment, quality performance and marketing advantages. In addition, designed as administrative pricing, MA plans, unlike ACOs, are not designed to produce Congressional Budget Office (CBO) scored savings. Beyond the possibility of incenting service volume and exacerbating disparities, the MACRA Merit-Based Incentive Payment System (MIPS) percent bonuses, structured as per unit rate increases, may actually disincent providers, the opposite effect of what MACRA intends, from participating in APMs since the APM pathway pays a less attractive bonus based on the previous year's reimbursement.⁵

Among other reasons, participating Medicare providers would want to know which program in which market is the most spending efficient. With MA and ACO quality performance measured against FFS, providers in FFS, who are now subject to MACRA MIPS, would be able to use quality performance to compete for market share. Since CMS intends to publish MIPS component scores, including quality and cost, by individual provider, providers will be able to market their quality and spending efficiency performance. Providers participating in ACOs continue to seek a more level playing field with MA, particularly as it relates to quality performance rewards and risk adjustment. If MA plans had to compete they would be more motivated to financially incent their providers who, in turn, would make them more likely eligible for the five percent annual Part B bonus under the MACRA APM pathway.

Beneficiaries would enjoy more credible choice. MedPAC is rightly concerned about the disruptive effect on beneficiaries or those in plans proving to be less efficient. The

Reduce Adverse Selection in Exchange Plans,” *Health Affairs* Blog (April 14, 2017) at: <https://www.healthaffairs.org/doi/10.1377/hblog20170414.059663/full/>.

5 J. Michael McWilliams. “MACRA: Big Fix or Big Problem?” *Annals of Internal Medicine* (May 16, 2017) at: <http://annals.org/aim/article/2627898/macra-big-fix-big-problem>.

commissioners realized due to loss aversion effects, beneficiaries would be less accepting of losing than gaining premium buying power. Because of considerable regional variation in Medicare spending, beneficiaries, as well as the taxpayer, are still left with the inequity that the beneficiary in a higher (less efficient) spending market has a higher premium than the beneficiary in a lower (more efficient) spending market. Also, beneficiaries who choose the most efficient plan in one market could still pay more in premiums than beneficiaries in the least efficient plan in another. An apparent remedy would be to set national premiums though this would inappropriately blame the beneficiary for regional variation.

Paying for Value

Per our above mention of paying for value, like all of healthcare, Medicare has a value problem. This means the agency does not measure for results. Like MACRA's four proposed and final rules and CMS' 2016 Quality Measurement Development Plan, the CMMI RFI only casually mentions value. For example, the RFI simply states the need to "align payments with value" and that benefit design be sufficiently flexible "to incentivize beneficiaries to choose high-value services." CMS needs to define value in a meaningful way. This means working intentionally to improve program value by incenting delivery performance that improves value defined as, Michael Porter has argued over the past decade, outcomes achieved relative to spending.⁶ Currently, CMS does not measure for value. For example, there currently is no correlation between quality performance and earned shared savings under the MSSP. ACOs that earned shared savings in 2016 did not have better quality scores than those that did not, even those that fell below their negative Medical Loss Ratio (MLR).⁷ Similarly, CMS' Hospital Value-Based Purchasing program (VBP) financially rewards low spending hospitals that are also low quality (and recent research shows may as well be exacerbating disparities).⁸ The MIPS program also does not measure for value. MIPS quality and cost components are scored independently.

In announcing in late October the agency's "Meaningful Measures" initiative, CMS Administrator Seema Verma admitted "how we define value and quality today is a problem" because it is not clear measures used today are, she said, "improving patient outcomes."⁹ This is largely because the agency and its partners have failed to create an ample number of outcome measures. What poses for quality measurement is instead effectively process compliance. As noted in a recent World Economic Forum report, only seven percent of the nearly 2,000 quality indicators in the Agency for Healthcare Research and Quality's (AHRQ's) National Quality Measures Clearinghouse are outcome measures.¹⁰ Going forward, the agency, Verma stated, "aims to focus on outcome-based measures."

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- 6 See, for example, Michael Porter, "What Is Value in Healthcare,?" [The New England Journal of Medicine](http://www.nejm.org/doi/full/10.1056/NEJMp1011024#t=article) (December 23, 2010) at: <http://www.nejm.org/doi/full/10.1056/NEJMp1011024#t=article>.
 - 7 See: <https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/2016-Shared-Savings-Program-SSP-Accountable-Care-O/3jk5-q6dr>.
 - 8 Anup Das, et al., Adding A Spending Metric To Medicare's Value-Based Purchasing Program Rewarded Low-Quality Hospitals," [Health Affairs](https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.1190) (May 2016) at: <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.1190>.
 - 9 See: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-10-30.html>.
 - 10 World Economic Forum, "Value in Healthcare: Laying the Foundation for Health System Transformation," (April 2017), at: <https://www.weforum.org/reports/value-in-healthcare-laying-the-foundation-for-health-system-transformation>.

An obvious path forward is for CMS to work with the International Consortium for Health Outcomes Measurement (ICHOM).¹¹ The consortium, that recently attracted 600 health care professionals from 30 countries to a Washington, D.C. conference, currently has 22 standard outcome measure sets the consortium estimates covers 50 percent of the global disease burden. CMS and the National Quality Forum are well aware of ICHOM's work and recognize the fact the agency can do more to collaborate internationally in the development, use and reporting of outcome-based measures. It is not too surprising of the 32 measures CMS forwarded last fall to the NQF's Measures Application Partnership (MAP) for endorsement, seven are patient-reported outcome measures. This past January ICHOM and the OECD signed a letter of intent to collaborate on the collection, analysis and publishing of patient outcomes that we hope encourages CMS to exploit ICHOM's work.

The RFI states the need to "improve access to and the quality of information that Americans need to make informed health care decisions, including data about healthcare prices and outcomes, while minimizing reporting burdens on affected plans, providers, or payers." Patient-reported outcomes is one tool that does both.

Conclusion

Medicare is not a unified program. There's neither a coherent whole nor any synergy. Medicare is simply the sum of its parts. As a result, the RFI appropriately recognizes beneficiaries or consumers are left with limited affordable choices. In sum, the RFI states, consumers are left with "many healthcare services providing too little value to consumers." AMGA strongly supports regulatory movement toward competing Medicare silos and intentionally driving to value. We are confident that taking regulatory steps in these directions would encourage and enable "the development and operation of a healthcare system that provides high-quality care at affordable prices."

Thank you for your consideration of AMGA's comments. If you have any questions please contact David Introcaso, Ph.D., Senior Director of Regulatory and Public Policy, at dintrocaso@amga.org or at 703.894.0774.

Sincerely,



Jerry Penso, MD, MBA
President and Chief Executive Officer
AMGA

11 See: <http://www.ichom.org/>.