AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

September 4, 2018

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

*Re: CMS-10673 – Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration*

Dear Administrator Verma:

We appreciate the opportunity to submit these public comments in response to the Agency's collection of information on the proposed Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration. Thank you for recognizing the important role Medicare Advantage (MA) and MA providers play in moving our nation's healthcare system from volume to value.

For years, America's Physician Groups (APG) has asked the Centers for Medicare & Medicaid Services (CMS) to use their authority to adopt an advanced alternative payment model (APM) demonstration project in MA that could create an additional avenue for physicians (primary care and specialists) to become advanced APM qualifying participants. While the proposed MAQI Demonstration does not go this far, it does represent an important step towards better integration of MA under the Medicare Access and Chip Reauthorization Act of 2015 (MACRA), and a positive development for the value movement overall. APG looks forward to continuing to work with you to ensure that MA providers have increased opportunities to become advanced APM qualifying participants.

APG represents over 300 medical groups and independent practice associations (IPAs) across 43 states, the District of Columbia, and Puerto Rico. Our members participate in value-based payment models across all of Medicare, and participate in numerous existing Innovation Center initiatives, including the Next Generation ACO program, the Bundled Payment for Care Improvement initiative (BPCI), and Comprehensive Primary Care Plus (CPC+). Moreover, many APG members have successfully operated under full risk-based models for over two decades and have a wealth of experience developing the necessary infrastructure. Their success across a wide variety of socioeconomic and geographic areas makes them invaluable as subject matter experts for your staff.

**Context for our Recommendations**

APG members are truly taking responsibility for America's health by holding themselves accountable for both the cost and quality of care by providing the patients and communities they serve with access to the best possible healthcare. Our preferred model of capitated, coordinated care avoids incentives for the high utilization associated with fee-for-service (FFS) reimbursement. Instead, we believe that our model aligns incentives for physicians to provide the right care in the right setting, thus improving the health of entire populations, particularly those with chronically ill and fragile individuals.

We believe that capitated payments allow our members to deploy proven techniques as well as test innovative approaches to patient care. Our model incentivizes a team-based approach, whereby healthcare professionals such as care managers, nurses, social workers, care navigators, pharmacists and others are deployed as part of a physician-led care team. Each member of the team is encouraged to practice at the top of his or her license.

While there are some avenues for this type of model in traditional Medicare, APG members recognize that capitated MA offers a more effective path with additional tools to engage in this type of care delivery.

As you know, there is wide variation in healthcare costs and quality throughout our country. The Integrated Healthcare Association (IHA) recently released its California Regional Health Care Cost & Quality Atlas 2.0, which tracks cost and quality measures across the state for over 29 million beneficiaries and compares different levels of integration on a multi-payer platform with commercial insurance, Medicare, and Medi-Cal data. Not only did the Atlas 2.0 study find that the average risk-adjusted cost per patient for coordinated products (HMOs) were 10 percent less that uncoordinated (PPO) products, they found that in MA the average risk-adjusted, per-member-per-year cost was 25 percent less than traditional Medicare.[1] MA also vastly outperformed traditional Medicare on hospital utilization, and, most importantly, clinical quality. The data is clear – capitated MA offers superior value with higher quality performance and overall lower cost.

Millions of Americans depend on MA for quality, patient-centered health care and that number is growing fast; over one-third of all Medicare beneficiaries are now enrolled in a MA plan. For the ultimate goal of MACRA to be realized, MA must no longer be excluded from the programs and incentives therein. The recently announced MAQI Demonstration is an important acknowledgment of the innovative value displayed by many MA plans. APG believes, however, that this proposed demonstration can and should go further by affording full advanced APM status to qualified participants thus allowing the participants to receive the 5 percent advanced Alternative Payment Model Status bonus payment. The current MAQI demonstration that only grants a waiver from MIPS reporting is inadequate to support the movement of volume to value with the MA population.

**Recommendations to Improve the Proposed MAQI Demonstration**

- Under MACRA, certain qualifying models can become eligible for advanced APM status. The statute defines bonus-eligible advanced APMs to include Innovation Center demonstration projects, certain Medicare Shared Savings Program (MSSP) ACOs, and demonstrations required by federal law; the MAQI demonstration is among these.

  However, currently, to qualify for the five percent advanced APM bonus, APMs must have a certain threshold of their Part B revenue or patients in an advanced APM. For the first two years of MACRA implementation, that threshold has been spelled out to in include 25 percent of Part B payments or 20 percent of Part B patients. In later years, the Medicare Part B threshold increases to 50 percent and then 75 percent.

  Under current regulations and sub-regulatory guidance, only a handful of models qualify as advanced APMs with the majority of these models being tested through Innovation Center demonstrations. These existing CMMI models show promise but have thus far exhibited mixed results and modest success. Currently, no MA arrangements count as advanced APMs (only

[1] *Integrated Healthcare Association. (2018). California Regional Health Care Cost & Quality Atlas 2.0. Retrieved from https://costatlas.iha.org/*

within the "other payer" category) and MA risk contracts do not count toward an organization's Medicare risk threshold.

The limited number of models in Part B do not offer sufficiently attractive or numerous options for physician groups who want to qualify as advanced APMs. CMS clearly needs to swiftly adopt new advanced alternative payment models to remedy this problem. We believe that the fastest and most equitable way to do this is through the MAQI demonstration that would allow a 5 percent bonus opportunity for participants. The MAQI demonstration does allows participants to receive a waiver from MIPS, however, that incentive alone is simply not adequate to move additional physicians to value. Many of our members who participate in risk-based MA contracts scored high on MIPS in 2017 due to their level of experience in providing coordinated care. Receiving a waiver exempting them from MIPS when they received over a 90 score in 2017 appears to be a hollow reward.

- The MAQI RFI comments are due September 4, 2018 and the MAQI application portal is open from August 6, 2018 through September 6, 2018, a timeframe which indicates that industry feedback will not be incorporated into the application. We recommend that the application deadline remain open until November 6, 2018 so CMS may review the industry recommendations and possibly modify the application.

- We have noted that the MAQI applications are only accepted from individual clinicians rather than at the TIN or physician group level. Not only is this inconsistent with MIPS reporting options in which one can report at either the NPI, TIN, or APM entity level, but MA risk-based contracts are organized at the practice level. Thus, having individual physicians apply to participate in MAQI is causing undue burden and confusion. This requirement should be modified to include an opportunity for the participants to submit their data at the TIN (practice) level in addition to the NPI (individual) level.

- The CMMI MAQI website does not include a PDF of the application which is typically found in other models. In order to review the application, we had to contact a CMS official through email to review the application for our members. A PDF of the both applications (threshold and qualifying arrangement form) should be inserted on the MAQI Demonstration webpage found under the CMMI models.

- The MAQI demonstration requires the same amount of information needed to qualify as an "other payer" to receive the 5 percent QP bonus. This seems inconsistent in that the same amount of activity is needed to receive a 5 percent bonus as to be exempt from MIPS (and receive zero). We would recommend that the application is modified and considerably shortened.

- The MAQI RFI has indicated that an estimated 15 hours per clinician will be needed to complete the application. It is stated that this is not an undue burden because participants will not be required to submit MIPS data. We disagree with this assumption and believe that the application will cause undue burden which is not representative of CMS's goals in reducing clinician burden. It is 15 hours per clinician thus the amount is multiplied across the practice since the TIN can not apply as an entity. Additionally, the MAO risk-based contracts require the same level of reporting as MIPS (in order to qualify as an advanced APM) thus no time is

eliminated. This will lead to decreased time spent in patient care which leads to clinician burnout.

We believe that due to the above implementation issues, the projected number by CMS of 100,000 clinicians participating in this demonstration is vastly overestimated. We fear that many physician groups will decide not to participate due to the complexity of the application process and the lack of reporting as a TIN. The goals of the MAQI demonstration, which include testing questions such as if the MAQI demonstration can lead to increased participation as a Qualifying Professional in the "other payer" category to receive the 5 percent bonus or could lead to utilization changes that impact MA bids, are important areas for us to understand. However, we fear the current structure of the demonstration will lead to a very limited number of participants and that results will thus be difficult to quantify with statistical accuracy.

More importantly, as we have previously stated providing a waiver from MIPS reporting instead of allowing the MA risk-based arrangement to count the same as a Medicare FFS arrangement to qualify for the 5 percent bonus is a poor substitute. It may be attractive to performers hoping to avoid MIPS penalties, but the exemption won't be attractive to those who are very experienced in providing coordinated care and wanting to receive MIPS bonuses to keep up with cost inflation. An exemption from a bonus is not much of incentive especially if practice received a high MIPS score in 2017 as many of our members did that participate in these types of arrangements. We continue to ask CMMI to modify the MAQI demonstration and allow the participants to qualify for the 5 percent bonus outside of the other payer category.

**Conclusion**

We appreciate the opportunity to submit these comments and offer ourselves and our members as a resource to you as you work to adjust and implement the MAQI demonstration. Please do not hesitate to contact me or my Federal Affairs staff (Valinda Rutledge, VP of Federal Affairs vrutledge@apg.org ; Margaret Peterson, Director of Federal Affairs mpeterson@apg.org) with any questions you may have.

Sincerely,

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