



The Voice of Accountable Physician Groups

**MACRA: Medicare Advantage Alternative Payment Models Should Count in 2019
Toward the Alternative Payment Model Threshold**

Today, Medicare Advantage enrollment makes up nearly a third of overall Medicare enrollment. The MA program has seen explosive growth, due in large part to the superior value it provides for seniors. All indications are that this program will continue to grow at a rapid clip in the coming years. However, under the Medicare Access and CHIP Reauthorization Act (MACRA), Medicare Advantage alternative payment models (APMs) are included only in the all-payer threshold beginning in 2021. MA's inclusion in the All-Payer Threshold is an important step but does not go far enough to recognize the value and importance of this program in achieving high quality, risk-based coordinated care. Physician groups should be able to qualify for APM incentives based on their participation in Medicare Advantage APMs for 2019 to 2024.

We encourage three important steps to remedy the problem:

- **First, rather than a Medicare Part B threshold, organizations should be able to qualify based on a Medicare threshold** (Medicare Part B and Medicare Advantage). MA contracts that include payment with more than nominal financial risk should count toward achieving the Medicare threshold for 2019-2024. APM contracts between MA plans and physician organizations where the physician group takes more than nominal financial risk, including capitation, should then explicitly count toward achieving this Medicare threshold.
- **Second, the same financial incentives for risk in traditional Medicare should be available for physician groups taking risk in MA.** That is to say, for a group that participates in MA, the APM incentive should apply to their MA revenue for physician services, not just their Part B revenue. This incentive should be paid directly to the physician or physician group taking the risk. The structure should be the same as MACRA: once a physician organization exceeds the threshold for risk, bonuses should be paid equally for both traditional Medicare and Medicare Advantage. The amount of the bonus should be adjusted to account for the financial incentives for health plans (our third recommendation).
- **Third, financial incentives should be available to health plans that enter into two-sided risk arrangements with physician groups.** With increasing frequency, CAPG hears from its members—among the most sophisticated risk-bearing physician organizations in the country—that many health plans are unwilling to offer risk-bearing arrangements to capable physician groups. Therefore, we encourage you to consider incentives for plans

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that enter capitated, delegated arrangements with physician groups. We believe that this type of incentive could be achieved through the Star Ratings program.

We believe this incentive structure is important for several reasons. Research shows that Medicare Advantage, when offered through an integrated, capitated delivery system (which is an APM and should be deemed as such), provides higher quality for seniors than traditional Medicare. The quality difference is striking. For example, some CAPG members have readmission rates as low as six or eight percent as compared to a fee-for-service average readmission rate that hovers around 18 percent. Medicare Advantage plays a crucial role in advancing high quality care for seniors.

In addition to being a high value option for seniors, Medicare Advantage plays a critical role in delivery system reform. While physician relationships with health plans generally are on the same trajectory from fee-for-service to alternative payment models, Medicare Advantage has the distinct advantage of having already “reached the destination” when it comes to risk-bearing relationships with providers. While not every arrangement between a plan and physician is risk bearing, Medicare Advantage is the one place today where two-sided risk-bearing relationships between payers and providers not only exist, but succeed. Some CAPG members currently participate in two-sided risk arrangements, including capitation, with health plans in Medicare Advantage. Other CAPG members are actively seeking out these relationships. But there are still large swaths of the United States where these types of risk-bearing relationships do not exist and should be encouraged. CAPG has tried to gather information about what percentage of MA is tied to risk-bearing or capitated arrangements, but has not been able to determine the percentage with certainty. We estimate that less than 20 percent of MA is currently capitated when considering the relationship between the health plan and the physician group. This represents substantial opportunity to improve care for seniors.

As a final note, the Affordable Care Act sought to achieve parity between Medicare Advantage and traditional Medicare, bringing the MA benchmarks, on average, to 100 percent of fee-for-service across the country. We believe that MACRA has inadvertently tipped the balance in favor of traditional Medicare, offering payments substantially above 100 percent of fee-for-service in traditional Medicare but not in Medicare Advantage. Yet all the while, MA has offered the most innovative, advanced payment arrangements in Medicare. CAPG looks forward to continuing to work with Congress and the Administration to explore ways of advancing delivery system reform across all of Medicare.