



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

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

Dear Ms. Verma:

AMGA appreciates the opportunity to comment on the Centers for Medicare and Medicaid Innovation's (CMMI) "Innovation Center New Direction" Request for Information (RFI). 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 strongly support CMMI's programming efforts and participate in many of CMMI's demonstrations, including most if not all of CMMI's demonstrations that qualify as Alternative Payment Models (APMs) under the Center for Medicare and Medicaid Service's (CMS') Quality Payment Program (QPP).

To begin, we have one overarching comment. The "New Direction" RFI makes repeated mention of market forces and beneficiary choice. The RFI's overall intent is, as CMS states, to "test market-driven reforms" and "reduce costs" by "engaging beneficiaries," "empowering consumers" and better "informing beneficiaries about their choices." Thematically, the RFI asks stakeholders to offer demonstration programming ideas that improve beneficiary education such that they can make more informed coverage choices. AMGA has long supported this goal both in previous comment letters and in published essays. In these writings AMGA has argued beneficiaries would be more "engaged," "empowered" and Medicare costs would be "reduced" if CMS intentionally competed Medicare Fee For Service, Accountable Care Organizations (ACOs) and Medicare Advantage (MA) programs.

The below comments are noted under the appropriate RFI focus areas.

Expanded Opportunities for Participation in Advanced APMs

Further Demonstrate ACO Innovations: CMS is well aware that the ACO program and the Pioneer demonstration have achieved limited or modest success over the past five years, or between 2012 and 2016. CMS' Public Use File (PUF) data and data made available by CMS' contractor, RTI, showed that, for example, [for performance year 2016](#), only 129 out of 432 MSSP ACOs earned share savings checks. The 30 percent of successful ACOs in 2016 was similar to the 29 percent in

2016, 26 percent in 2015 and 27 percent in 2014. Shared savings paid out, at slightly more than \$700 million, on \$82 billion in total spending, was again highly concentrated. The 15 highest performing 2016 ACOs received \$265 million total in shared savings as compared to the 15 lowest performing shared savings ACOs that received \$20 million in total. Success was largely determined by an ACO's financial benchmark. ACOs that earned shared savings in 2016 had a reconciled benchmark 10% higher than all other ACOs, or respectively \$11,614 per beneficiary versus \$10,563 per beneficiary. Concerning quality performance, as in previous years ACOs earning shared savings did not measurably outperform all other ACOs. Specifically, 94.88 percent versus 94.59 percent, respectively. Those ACOs that fell below of their negative MLR had a mean quality score of 98.6%.

We note these statistics to suggest there is ample opportunity for innovative demonstrations to improve MSSP performance. Many of these proposed innovations have been discussed at length by ACO stakeholders in numerous comment letters in response to proposed MSSP rules. These include, for example, changes to beneficiary assignment and engagement, changes to risk adjustment for the continuously assigned and making claims data more timely.

Despite being in its sixth performance year, the vast majority of ACO participants remain in the "no risk" Track 1, or 95 percent in 2016 (410 out of 432). The question remains begged how to incent providers to take on an ACO downside risk contract. (Per a recent [IOG report](#) the MSSP has saved just \$1 billion in its first three years. Medicare spending in 2016 was \$689 billion.) To accelerate Track 1 ACOs ability to take on financial risk CMS in its December 2014 ACO proposed rule discussed "possible alternatives" that would allow ACOs to annually "split their ACO participant TIN list into different risk tracks" during an agreement period. In this "segmented lists" discussion, the agency outlined seven criteria to accomplish this. We note this related, previous discussion because allowing ACOs to annually, incrementally move into risk arrangements would prove to be valuable. Allowing an ACO to "accept varying degrees of risk" within an agreement period would position the ACO to balance its exposure to and tolerance for financial risk. This flexibility would create another glide path for providers. Quality measurement could remain the same but reported by risk track. Benchmarking could be the same if the option was limited to moving to Track 2. ACOs could also manage sub-populations either by retrospective or prospective assignment.

Field Full Episode of Care Bundle Demonstrations: (We make this comment under this focus area recognizing under, "Consumer-Directed Care and Market-Based Innovation Models," CMS notes "offering bundled payments for full episodes of care.") As we have argued in CMS proposed rule comment letters, among other things, short term bundled payment arrangements run the risk of (further) fragmenting care and/or compromising care coordination. If designed or demonstrated as full episode bundles or bundles for full cycles of care, these models can offer the beneficiary greater choice and value and make the Medicare program more spending efficient. For chronic conditions the defined period would likely be a year. For example, the Netherlands has been treating type 2 diabetes for the past ten years and COPD patients for the past seven years under bundle payment arrangements. We propose full episode bundles as a compliment to other pay for performance reforms. For example, an ACO could identify a cohort or sub-population of assigned beneficiaries that share a chronic condition for which the ACO cares for under a full episode bundle payment arrangement. Some termed these "shadow bundles." This solves or addresses three immediate problems. Approximately half of the 48 Bundled Payments for Care Improvement (BPCI) episodes do not lend themselves to 30 to 90 day bundles, such as

congestive heart failure, COPD and diabetes. Second, imbedding a full episode bundled in an ACO avoids, using CMS' phrase, having to “account for overlap,” an intractable overlap problem with no satisfying solution. Third, it is anticipated CMS is soon to announce an advanced BPCI demonstration. We encourage CMS to offer full episode arrangements under an advanced BPCI demonstration. Appropriately constructed, these full BPCI episodes could also be defined as an APM.

Improving HIT Interoperability: [Recent research published in Health Affairs](#) concluded that only 30 percent of hospitals in 2015 met all four domains of HIT interoperability: electronically finding; sending; receiving; and, integrating information into electronic health records from outside providers. This was a modest gain compared to 25 percent of hospitals in 2014. It appears the Office of the National Coordinator's (ONC's) 2018 national objective of “widespread interoperability” will not be met. As the authors conclude, absent interoperability, hospitals asked to become APM partners will be required to provide “better management of patient populations” which will be “difficult to achieve without robust interoperability.” If APMs are to be adopted on a widespread scale, this issue needs to be a priority. The Innovation Center should work to test incentives to increase HIT interoperability.

Better Engage the Health Care Plan Learning Action Network (HCPLAN): CMS created the HCPLAN “to help advance the work being done across sectors to increase the adoption of value-based payments and alternative payment models (APMs).” AMGA has been a strong supporter of the LAN. We have written at least four comment letters in response to LAN white papers over the past two years. Generally, we believe the LAN could be more effective in spreading CMS/CMMI driven payment model innovation. For example, regrettably the LAN has recently rejected the idea of developing operational and tactical support for commercial ACOs.

Consumer-Directed Care & Market-Based Innovation Models

Pursue Value: CMS states the agency “believes beneficiaries should be empowered as consumers to drive change.” We interpret this to mean CMS is interested in providing beneficiaries with greater value for their Medicare premium. AMGA has written at length that CMS should work towards measuring for value, meaning equate quality with spending or calculate health care outcomes achieved relative to spending. AMGA has argued quality and spending be correlated in at least seven comment letters: our September 2017 comment letter in response to the Yale's white paper titled, “[Hospital Quality Star Rating on Hospital Compare, Public Input Period](#)” (subtitled, “Enhancement of the Overall Hospital Quality Star Rating”); our August 2017 comment letter in response to the proposed 2018 MACRA rule; our June 2017 response to HCPLAN's Alternative Payment Model Framework; our April 2017 response to CMS' Episode-Based Cost Measure Development for the Quality Payment Program; our June 2016 response to the MACRA proposed rule; our June 2016 response to HCPLAN's Performance Measurement White Paper; and, in our March 2016 response to CMS' Proposed Quality Measurement Development Plan.

Despite the considerable amount of financial resources providers are required to expend, clearly noted in CMS' 2018 MACRA proposed and final rule impact tables, there is, again, no correlation between quality and spending, or no measurement of value, in the MSSP program. As for hospitals, as Anup Das and his colleagues noted in their May 2016 [Health Affairs](#) essay, “[Adding A Spending Metric To Medicare's Value-Based Purchasing Program Rewarded Low-Quality Hospitals](#),” when CMS added a spending measure in 2015 to the Hospital Value Based Program

(HVBP) program, low-spending hospitals that received bonuses increased from 38 percent in 2014 to 100 percent in 2015. This was despite the fact that low-quality hospitals, the authors found, “performed significantly worse on almost all measures of quality, compared to the medium- and high-quality hospitals that received bonuses.”

CMS has motivation and opportunity to test or demonstrate measuring for value. Beyond having to build out the MACRA MIPS cost component, CMS should, over time, correlate the MIPS quality component with the cost component. MACRA funds \$15 million annually between 2015 and 2019 to identify gaps in MIPS quality measures. These funds could be used to test new quality measures that align with MACRA's goal to develop "measures that reflect efforts to lower costs and significantly improve outcomes." CMS could also work with the International Consortium for Health Outcomes Measurement (ICHOM) to both exploit and develop additional and much needed outcome measures. ICHOM currently fields 22 measure sets that the organization argues covers half of the world-wide disease burden. Working with ICHOM also provides an opportunity to compare Medicare program performance internationally.

California's Integrated Healthcare Association's (IHA's) value based pay for performance program imposes both quality and spending thresholds. If neither threshold is met, the provider or provider group's performance score is reduced. (In 2016 Andrew M. Ryan and his colleagues published in [Medical Care Research and Review](#) a review of seven methodological approaches that combine quality and spending to measure for efficiency.) Measuring for value could also be forwarded via how the agency builds out MACRA-required care episode and patient condition group codes that are intended to improve resource use measurement. Hospital-based bundled payment arrangements, for example, ideally lend themselves to value-base performance measurement scoring since they are intentionally designed to drive improved outcomes over spending.

Patient Reported Outcomes (PROs)/Patient Report Outcome Measures (PROMs):

Currently, participants in the Comprehensive Care for Joint Replacement (CJR) demonstration can voluntarily report patient functional status. ACOs use a patient reported depression measure. CMS is anticipated to make a Measure Development Plan-related funding announcement that will in part emphasize PROMs and we understand CMS participates as a member of the ICHOM steering committee. Also, it is anticipated this year's National Quality Forum's (NQF) Measure Applications Partnership (MAP) process will also address this issue. The NQF published a PROM-related report this past August titled, “[Measuring What Matters to Patients](#).” Since CMS emphasizes in this RFI “patient centered” care and improving care quality and choice, AMGA strongly encourages the agency to develop and test more PROM-related quality measures.

Under this focus area AMGA would be remiss the association did not again note its concern regarding risk adjusting performance measures. Specifically, our continuing concern that CMS test accounting for social risk factors in developing quality measurement risk adjustment approaches.

Data Transparency: This focus area notes, “beneficiaries should be empowered as consumer” and “CMS may develop models to facilitate and encourage price and quality transparency.” Therefore, AMGA recommends CMS make fully transparent ACO performance data including making the agency's Shared Saving Portal (SSP), which is currently available to only ACO

participants, publicly available. Similarly, AMGA also supports bundled payment data or performance transparency. For example, beneficiaries ought to be able to evaluate a lower extremity joint replacement by a setting's cost a quality performance. For example, how does a hospital's hip replacement procedure compare against an ambulatory surgical centers in the same market.

ACO Participation and Sharing in Saving and ACO Enrollment: This focus area also notes "beneficiaries could choose to participate in arrangements that would allow them to keep some of the savings." We encourage CMS to demonstrate or demonstrate further a beneficiary's ability to share in savings. This should exceed the current Next Generation ACO coordinated care reward of \$50 annually. Per CMS' statement, "Models we are considering testing include allowing beneficiaries to contract directly with healthcare providers." We support allowing beneficiaries to choose to enroll in an ACO demonstration.

Physician Specialty Models

PTAC: AMGA supports the work of the Physician-Focused Payment Model Technical Advisory Committee (PTAC). This past April the PTAC has recommended for limited testing Project Sonar and the ACS-Brandeis Advanced APM. In September the PTAC also recommended for limited testing Hackensack Meridian's Oncology Bundled Payment Program model as well as the Ichan School of Medicine at Mount Sinai's HAH Plus or Hospital at Home Plus model. Per PTAC's enabling legislation, the "Secretary shall review the comments and recommendations submitted by the Committee . . . and post a detailed response to such comments and recommendations on the Internet website of the Centers for Medicare and Medicaid services." We encourage the Secretary to promptly comment on or field these four PTAC recommendations.

Medicare Advantage

Support Testing MA as an Advanced APM in Performance Year 2018: In our August 21 comment letter in response to the proposed 2018 MACRA rule, we supported the agency's proposal to use its demonstration authority to include in performance year 2018 MA under the all payer APM option. We are pleased CMS finalized this decision in the 2018 MACRA final rule. AMGA recently forwarded a letter to the Administrator again expressing support of a MA APM demo.

Expand the MA Value-based Insurance Design (VBID) Demonstration: The VBID demonstration began this year in seven states and is designed to expand to 10 states in 2018. The demonstration is currently addressing nine major chronic conditions that is designed to expand to 11 in 2018. Currently, there are only nine plans in three states participating. Since CMMI is fielding only one other demonstration that includes a few MA plans, the Oncology Care Model, CMMI should work to expand participation in its VBID demonstration.

Publicly Report MA versus ACO Quality Performance: CMS states in this RFI the agency is interested in "promoting competition based on quality." In theory, a Medicare beneficiary could learn how each MSSP ACO performed on each of the 34 ACO quality measures via <https://data.cms.gov/>. 2016 quality performance for each MSSP ACO is at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/SSPACO/index.html>. A beneficiary wanting to compare ACO quality performance against MA quality performance could identify via CMS' website quality performance by each quality measure for all MA plans in their region. However, this would not be instructive because MA quality star scores noted are the average score for however many markets in which a plan

participates, not the score for the plan's performance in the beneficiary's specific zip code. Perhaps not surprisingly, CMS recently announced the agency is in the early stages of developing Medicaid and CHIP scorecards that would publish Medicaid outcomes by state. Per our comments above regarding the HCPLAN, it is worth noting in the commercial sector, a recent report by the Altarum and the Catalyst for Payment Reform graded 42 states with an "F" on quality transparency. Again, to "engage beneficiaries" and "empower consumers, CMMI should demonstrate quality score transparency.

State-Based and Local Innovation, Including Medicaid-focused Models

Demonstrate Oregon's Coordinated Care Organizations (CCOs): Oregon's 1115 Medicaid waiver CCO pay for performance program (in 2016 quality pool dollars equaled 4.25 percent of monthly payments) has been nationally recognized for providing integrated, team-based, patient-centered care that is also population based and focused on reducing health care disparities. The program is also noted for its ability to offer social service supports along with medical benefits and for its Community Paramedicine Program. In 2016, counting challenge pool dollars, seven of the 16 CCOs earned above 100 percent of their quality pool dollars and six earned more than 90 percent. Beyond quality improvement and spending efficiency the program is demonstrating favorable spillover effects in the commercial plan market. We encourage CMMI to work to spread CCO innovations within and beyond the Medicaid program.

Mental and Behavioral Health

Extend Telehealth Demonstration Waivers: To date CMMI has extended telehealth waivers to the Comprehensive Care for Joint Replacement (CJR), ESRD Care (CEC), Comprehensive Primary Care Plus (CPC+) and Next Generation ACO demonstrations. All demonstrations should equally benefit from a telehealth waiver, particularly those that are also designated as APMs, i.e., the Oncology Care Model (OCM). AMGA also encourages CMS to provide telehealth waivers in all ACOs or Track 1, Track 1+, Track 2 and Track 3.

Test Inclusion of Mental/Behavioral Health Clinicians in APMs: Under MACRA, there are five Eligible Professionals (EPs) identified for the 2017 and 2018 performance year and CMS proposes to add eight more EPs beginning in performance year 2019. While none of the initial five are mental or behavioral health clinicians, the eight EPs proposed for 2019 include clinical social workers and clinical psychologists. [According to the CDC](#) approximately 20% of all visits to primary care physicians in 2010 included at least one of the following five mental health indicators: depression screening; counseling; a mental health diagnosis or reason for visit; psychotherapy; or provision of a psychotropic drug. For individuals older than 75, 31 percent of primary care visits were based on one or more of these five indicators. Because mental/behavioral health is poorly integrated into primary care, primary care clinicians are frequently inadequately trained in treating these diagnoses that causes as many as 50 percent of patients with a mental/behavioral health disorder to go undiagnosed, and because CMMI has done little if any work in improving mental/behavioral health, we urge CMMI to intentionally design into its primary care demonstrations, moreover ACOs, integration of mental/behavioral services.

Program Integrity

To Reduce Waste, Demo the Choosing Wisely Campaign: It is commonly estimated that up to 30 percent of care is either of no or low value, or constitutes waste. To address this problem the ABIM Foundation launched the Choosing Wisely campaign in 2012. The campaign today consists

of recommendations to avoid no or low value care by over 500 specialty societies. [Recent research](#) however found only 25 percent of physicians were aware of the campaign. Research has also found that organizational characteristics that reduced low-value care include a commitment measuring value. CMMI and Choosing Wisely are natural partners. We encourage the Innovation Center to partner with the Choosing Wisely campaign as it develops and reforms its demonstrations.

If you have any questions about these comments, please do not hesitate to contact David Introcaso, Ph.D., Senior Director of Regulatory and Public Policy, at dintrocaso@amga.org or at 703.842.0774.

Sincerely,

A handwritten signature in cursive script that reads "Jerry Penso".

Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer
AMGA