April 20, 2021

Liz Fowler
Director
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Fowler:

On behalf of AMGA, I would like to congratulate you on your appointment as Director of the Center for Medicare and Medicaid Innovation (CMMI), which designs, implements, and tests new healthcare payment models for the Centers for Medicare & Medicaid Services (CMS). AMGA and its membership remains firmly committed to supporting innovative value-based models; we look forward to working with you to develop models that result in better health, improved outcomes, and lower costs for all Americans.

Founded in 1950, AMGA represents more than 440 multispecialty medical groups and integrated delivery systems, representing about 175,000 physicians who care for one in three Americans. Our members’ on the ground experience with a variety of value-based models of care has taught them how to structure their care delivery models, so they can succeed in risk-based models. Among AMGA’s members, 145 participate in the Medicare Shared Savings Program, and 15 participate in the Next Generation ACO Model.

Recommendations for Harmonizing Delivery Models

AMGA maintains that the model of care delivery that our members offer is a superior way to ensure patients benefit from innovative medical practices and care. However, as the Medicare Payment Advisory Commission (MedPAC) concluded, Medicare Advantage and accountable care organizations (ACOs) “could serve as vehicles to broaden” value-based payments in Medicare, but only if their structures are improved.1 During its most recent meeting, MedPAC recommended that CMS “implement a more harmonized portfolio of fewer alternative payment models” that work together to improve quality and reduce spending. Based on our members’ experience with various value-based payment models, AMGA supports this recommendation.

Our members raise concerns about “model fatigue” that occurs when CMMI offers a new model. Many of these models’ rules on important issues like reporting requirements, financial benchmarks or measures often conflict, making it difficult for multi-specialty medical groups to
operationalize these models. If CMMI worked to create a more harmonious portfolio of models, with identical or at least similar requirements, this would eliminate some of the burden that results from determining which programs to participate in and how they all interact. We urge CMMI to work with the provider community to achieve this goal, as we believe it could quicken the transition to value.

We also have concerns on how potential applicants receive important details on available models. For example, as detailed below, there were significant delays in the release of the Global and Professional Direct Contracting model details. To that end, AMGA recommends that CMS provide sufficient notice about model details at the start of the process. Our members require a suitable amount of time in advance to prepare to participate in a CMMI demonstration, as they make decisions on how to allocate resources well in advance of the start of any given model. CMMI at times announces models with incomplete information, making it hard for our members to commit. As such, CMMI should ensure it only announces models when it is prepared to provide complete information on the financial methodology (and other policies). This will ensure our members are able to make an informed decision about their participation. At least 12 months prior to the beginning of a model is a suitable timeframe.

AMGA also has several recommendations on the structure of value-based models. Any value-based model needs to offer sufficient opportunities to earn shared savings to attract participants. The shared savings potential of a model must be sufficient to warrant the investments that providers must make to succeed in a value-based model. Any “upside-only” model should offer a shared savings rate of at least 50%. For those models with a downside risk component, 75% is the minimum.

In addition, CMS regulations that were developed and implemented in the fee-for-service environment do not account for the significant investment that is required to engage in these population health models, including those that, for the time being, are in a shared-savings only arrangement. Value-based models should offer the regulatory flexibilities based on the understanding that the volume concerns in a fee-for-service are not applicable. Limiting waivers and beneficiary incentive opportunities to only models with downside risk is a disservice to providers, patients, and the Medicare program. Instead, AMGA recommends that CMMI develop a common set of regulatory requirements and flexibilities for value-based models that do not vary based on the level of risk. For example, flexibilities regarding telehealth, skilled nursing care, and beneficiary incentives should not be based on the level of risk a particular model offers, but be available because these tools form the basis of any value-based reimbursement structure. Otherwise, providers will need to adjust how they deliver care based on a new regulatory structure, which not only makes it difficult to apply any lessons or knowledge to their care delivery processes, but also serves as a disincentive to enter into a model.

For example, outside the current public health emergency Medicare regulations limit the use of telehealth services and remote monitoring. However, the Medicare Shared Savings Program and the Next Generation ACO Model allow participants to apply for waivers that permit more flexibility with telehealth services. This expansion of telehealth services only applies to ACOs in performance-based risk models. Restricting the availability of the waivers to two-sided models does not help patients engage with their physicians. Clinicians in value-based models should have access to every possible tool to ensure the beneficiary receives the most efficient, highest quality care.
AMGA also recommends that CMS streamline quality measures across models to the extent possible. Current quality reporting continues to be burdensome, contributing to burnout and added costs for providers. Research has indicated that annually U.S. physician practices in four common specialties spend more than $15.4 billion and, on average, 785 hours per physician to report quality measures. Additionally, our own members have reported the cost and burden associated with measure reporting. For example, a 2017 AMGA survey found that for every 100 physicians our members employ, 17 information technology (IT) professionals were needed to support them. These costs are much better spent on caring for patients, not maintaining an expensive IT infrastructure. Given the immense provider burden with very little added value, the Medicare program should reduce the number of quality measures for all value-based providers and move to a more outcomes-based system supported by claims data.

Direct Contracting Features AMGA Recommendations

While we believe CMMI needs to harmonize new model development, AMGA recommends that CMMI reconsider its decision not to accept applications for a 2022 start date for the Global and Professional Direct Contracting (GPDC) model, which incorporates many of AMGA’s model recommendations. AMGA is concerned that CMS did not take an aggregate view of the value-based landscape in reaching this decision. This unexpected cancellation came after CMS earlier announced providers could expect an application window to open in the first quarter of 2021 for a 2022 start date. This cancellation comes after a significant delay in the availability of all the details about the model, which our members need to make an informed decision on whether to participate. In addition, many of our members were preoccupied with responding to the COVID-19 pandemic when the application window was open for the 2021 performance period. Many of our providers, particularly those with experience in other models with downside risk, would be able to submit an application quickly if afforded the opportunity. Therefore, AMGA must object to both the timing and how CMS announced the change.

CMMI’s action sends a mixed message to the industry and AMGA members about the move to value. While CMS selected a number of AMGA members to participate in the GPDC Model, others were anticipating and preparing for an application window to open soon so they could participate beginning in January 2022. CMS’ decision leaves many AMGA members with a quandary. Not only were they prepared to leverage their years of experience with value-based care, but the cancellation also may have inadvertantly discouraged future participation. AMGA members dedicated significant resources to prepare to apply for participation in the GPDC Model, which for many of our members represented the next step in their continuation on the pathway to value-based care.

With the Next Generation ACO Model slated to end in 2021, prospective GPDC Model applicants now find their organization with no avenue to continue their transition into models with increased financial risk. AMGA and other stakeholders on April 12 wrote to Sec. Xavier Becerra on the importance of extending the Next Generation model through 2022. In addition, they may hesitate to invest in resources necessary to participate in a future model because of concerns that CMS may unilaterally opt to cancel it. In its description of the GPDC Model, CMS noted the model “will be attractive for former” Next Generation ACO participants, as the model offers a suite of flexible options on risk-sharing and a reduced set of quality measures that are outcomes focused. Now, it appears that neither option will be available for AMGA members.
The transition to value is beyond challenging. At the large medical group and health system level, it requires multimillion dollar investments, redesigning clinical care processes, revising provider compensation formulas and developing new financing and administrative systems. Just as challenging, it requires a significant shift in organizational culture. Given these challenges, we strongly believe that CMMI, and all federal and commercial payers, need to develop models that incentivize provider participation. In our members’ experience, this largely has not been the case. Given the importance of successfully moving the healthcare system to value, we would welcome the opportunity to discuss our experience with current CMMI models and our thoughts on future models with you and your team. Our members recognize how crucial population health and care coordination are to improved patient outcomes. Meeting with a select group of physician and system leaders from our member organizations would provide you with insights based on years of experience from providers who are at the forefront of reforming our healthcare delivery system.

I would be pleased to coordinate with an appropriate member of your staff, who can contact Darryl Drevna, our senior director of regulatory affairs at 703.838.0033 ext. 334 or ddrevna@amga.org. Thank you for your consideration.

Sincerely,

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

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1 MedPAC June 2020 Report to Congress