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October 28, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Slavitt:

AMGA welcomes the opportunity to comment on the "Request for Information on State Innovation Model Concepts." 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 many if not all Alternative Payment Models (APMs) including the Medicare Shared Savings Program (MSSP), the Pioneer and Next Generation Accountable Care Organization demonstrations, the two, soon to be three, bundled payment demonstrations, as well as in several other CMS demonstrations including the Comprehensive Primary Care (CPC) demonstration and the CPC+ demonstration. Therefore, AMGA has a strong interest in CMS continuing to support state efforts to develop and align multiple payers in Medicare APM arrangements.

In the nine-page State Innovation Model (SIM) Request for Information (RFI), CMS states, in part, the agency is generally interested in learning "ways to support broad payer and health care provider participation in alternative payment models." The RFI states further, "CMS invites comments on concepts for a future state-based initiatives that would support states to implement broad scale, multi-payment delivery and payment reforms." CMS is interested in pathways that would align Medicaid and private payers around an existing Medicare care model or demonstration. CMS also, among other things, seeks ways for states to leverage their role to reduce health care disparities across vulnerable populations.

Summarized, the comments below are based largely on RTI's evaluation of the SIM initiative. RTI's findings to date suggest there are substantial opportunities to target or better target future SIM programming in these five areas.

1. Accountable Care Organizations (ACOs)

The SIM RFI is interested in states aligning "Medicaid and private payers around one or more existing CMS models and initiatives," for example, the ACO program and demonstrations. According to the Center for Health Care Strategies, there are currently 10 states with Medicaid ACO programs

and six more states actively pursuing them. However, it appears from the RTI's evaluation employers or self-insured employers in SIM states are not engaged or widely participating in APMs or in state SIM programming. RTI stated in its August 2016 evaluation in Arkansas Walmart participates in the state Primary Care Medical Home (PCMH) and Episode of Care (EOC) models and has actively been encouraging other employers to participate. In Minnesota, RTI characterized employer involvement by quoting a stakeholder who commented, "it is my impression that . . . fully-insured employers . . . don't really know what is going on [regarding SIM programming]." We note this disconnect because several employers are contracting directly with ACO organizations, most notably Boeing. Beyond ACO contracts in Washington, Missouri and South Carolina, this past June the Boeing announced it is making available to its 15,000 southern California employees and dependents ACO care via a contract with MemorialCare Health System. Additionally, companies such as United Airlines, Lowe's and Walmart are also contracting directly with other APM model providers, for example, under bundled payment arrangements. AMGA encourages CMS to use future SIM funding to support state efforts to better align self-insured employer plans with APM programming.

CMS is scheduled to announce its Accountable Health Communities (ACH) demonstration participants before the end of this year. As noted in the AHC announcement, ACH's are designed to "bridge the divide between the clinical health care delivery system and community service providers to address . . . health-related social needs." Citing again the RTI evaluation, a few states, it appears Minnesota and Massachusetts principally, are working to integrate primary care with other health and social services, including behavioral health services and long-term services and supports and perhaps eventually to become next generation integrated health plans where social service organizations would participate in accountability for the total cost of care in a population and earn a portion of any shared savings. AMGA encourages future SIM funding support the expansion of the agency's ACH work.

2. Disparities

As noted above, the SIM RFI states, "CMS seeks input on how states might leverage their role to reduce disparities across vulnerable populations who experience increased barriers to accessing high quality health care and worse outcomes and what specific care interventions and data collection efforts are needed to address health disparities for these populations." Per RTI's SIM evaluation there appears to be little or no attention to date by states to address disparities. The only activity noted appears to be Oregon's effort publish on its website state-level reports on racial and ethnic disparities. Considering the lack of progress in reducing healthcare disparities, CMS should prioritize reducing disparities in future SIM funding. For example, the Agency for Healthcare Research and Quality (AHRQ) 2015 "Health Care Quality and Disparities Report" found poor households and minorities received worse care than people in high-income households and whites by 60 and 40 percent respectively,

3. Marketplaces

Over the past few months there has been considerable discussion or debate concerning the performance or stability of the Affordable Care Act (ACA)-created state insurance marketplaces. Again, per RTI's evaluation there appears to be little effort to use these marketplaces to further the goals of the SIM initiative. RTI did find that in Arkansas, the state has used marketplace policy levers to mandate PCMH participation among qualified health plans (QHPs) and Medicare Advantage (MA) Special Needs Plans (SNPs). AMGA believes the state marketplaces offer substantial opportunities to further the goals of the SIM initiative, particularly aligning state payers with APMs.

4. Medicare Advantage

On October 25, the Health Care Plan Learning Action Network (HCPLAN) released a report titled, "Measuring Progress." The report found, in part, 23 Medicare Advantage plans representing 9.6 million lives, or 57 percent of the Medicare Advantage market, reported that 41 percent of their 2016 spending was tied to APMs defined in either HCPLAN's category three or four. That means payments tied to upside gainsharing, downside risk, condition specific care or population based care. (The HCPLAN authors did recognize self-reporting may have biased their findings.) We note because, again, the 2016 RTI evaluation appears to show MA participation in the SIM initiative is minimal. RTI noted in Arkansas there is, again, some coordination between MA SNPs and the state's PCMH programming and in Oregon via some interaction with the state's Care Coordination Organizations (CCOs). If MA participation in APMs is as substantive as the HCPLAN survey suggests, there appears to be substantial opportunity for states to more fully partner far with MA via the SIM initiative.

5. PACE

In the CMS SIM memo, "Areas for Medicare Alignment in Multi Payer Models Under the State Innovation Models Initiative," the agency states, "a basic tenet of SIM is the belief that State governments can play a key role in coordinating efforts among payers and providers in their State." This statement is particularly relevant to Medicare PACE (Program for All-Inclusive Care for the Elderly), as its programming is contingent upon state Medicaid agency approval. Because the PACE care model:

- is substantially under-utilized, 18 states do not offer PACE and the program provides care for only approximately 35,000 beneficiaries;
- not being exploited by any SIM state or no SIM state is focused on the PACE population, i.e., the multi-comorbid frail elderly with particularly high rates of cognitive impairment (there is no mention of PACE in RTI's evaluation work); and,
- no longer requires PACE providers to be not-for-profit, i.e., there are for profit providers interested in providing PACE care;

for these reasons and others, CMS should exploit the SIM initiative to realize far wider adoption of PACE or PACE-like care in SIM states.

6. Specific Care Interventions Across Multiple States

CMS states in the SIM RFI the agency is interested in “assessing the impact of specific care interventions across states.” “States would forego the flexibility of varying the intervention,” CMS states further, “so as to standardize the intervention and improve the ability to make conclusions about the impact of specific interventions in multiple states.”

AMGA questions this approach. Attempting to test, or as is commonly termed “spread,” a specifically defined intervention across multiple states makes certain assumptions about the nature of research innovation and how innovation in the practice setting occurs. “Assessing the impact of a specific care intervention across states” assumes knowledge is first produced and then disseminated. That is new knowledge, here a clinical practice improvement, is a “thing” or an “it” that transfers like money from one person to another. Improving patient care simply becomes, as Don Berwick argued in 2005, a re-engineering effort to drive out variation or bring to ever larger scale uniform care delivery improvement. (See: Don Berwick, “The John Eisenberg Lecture: Health Services Research as a Citizen in Improvement,” Health Services Research (April 2005): 317-336.) Health care delivery, in sum, becomes manualized.

Unfortunately, as Martin Wood and others have persuasively argued, knowledge of a clinical practice improvement is rarely preformed, pre-existent or self-evident. (See, for example, Wood, et al., “Achieving Clinical Behaviour Change: A Case of Becoming Indeterminate,” Social Science and Medicine (198): 1729-1738.) The improvement is not, per Wood, “situated knowledge,” not meaning independent. Healthcare providers do not simply “apply disembodied scientific research to the situation around them.” They interpret and [re]construct its local validity and usefulness.” (Science determines only the strength of the evidence that exists for any particular hypothesis. It does not presuppose a purpose or end. That’s teleology.) If this were true reasons would be causes. If this were true all clinicians at all times would practice appropriate hand hygiene.

Atul Gawande's 2004 profile of Dr. Warren Warwick's success with his cystic fibrosis patients serves as an excellent example of Wood's argument. (See: Atul Gawande, “The Bell Curve,” The New Yorker, December 6, 2004.) Warwick's practice is primarily relational. While Gawande illustrates Warwick's success for other purposes, he does describe in detail Warwick's ongoing back and forth interactions with his patients. He focuses on Warwick's interaction with a particular young female during which Warwick tries to make sense of the patient's reduced lung capacity by persisting in asking her about coughs, colds, treatment frequency, etc. Eventually, Warwick learns the patient has a new boyfriend and job and for these reasons she had been skipping her treatments. Learning this, Warwick is now able to work out an agreed-upon, meaningful and effective treatment plan with his patient to reverse her functional decline. Warwick's approach is patient-specific, it is not a “specific care intervention.” It cannot be simply spread or tested in multiple states. Not surprisingly, Gawande notes Warwick is disdainful for clinical guidelines that he tells Gawande are, “a record of the past and little more.”



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As Thomas Kuhn noted in his famous work, The Structure of Scientific Revolutions, there is no research absent a conceptual paradigm. Here, the paradigm is new knowledge, again a discrete “thing” or “it,” is first obtained and then, being self-announcing or context free, is mechanistically and linearly transferred from one person or organization to another. This is the commonly expected paradigm, or in Kuhn's terms is, “normal science.” This explains why the Agency for Healthcare Research and Quality (AHRQ) terms its dissemination work “knowledge transfer” and manages a “knowledge transfer program” (at: <http://www.ahrq.gov/cpi/centers/ockt/kt/index.html>). This approach, this paradigm, has proven to be ineffective. For example, AHRQ's own Evidence Report (#213) regarding dissemination published November 2013, notes at pages ES 8 and 9, the “strength of evidence” for dissemination strategies commonly used by AHRQ is moreover “low” or “insufficient.” AMGA believes “assessing a specific care intervention across multiple states” is inherently, if not fatally, flawed. AMGA encourages CMS to take a more sophisticated view of how innovation occurs in, or across, clinical practice settings.

Thank you for your consideration of our comments. If you have any questions 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,

Donald W. Fisher, Ph.D.
President and CEO