November 20, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Centers for Medicare & Medicaid Services Innovation (CMMI) Center New Direction Request for Information

Dear Administrator Verma,

We appreciate this opportunity to provide our feedback on the future direction of CMS Innovation Center. We share CMS' goal of increasing participation in Advanced Alternative Payment Models (APMs) by creating additional opportunities that encourage provider flexibility and choice and reducing burdensome requirements and regulations that draw practice resources away from patient care.

Since 1926, the Medical Group Management Association (MGMA) has been the premiere association for professionals who lead medical practices. With a membership of more than 40,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 organizations of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

Increasing participation in Advanced APMs

In a July 2017 MGMA survey taken of over 750 group practices[1], 80% of respondents reported being very or extremely concerned about the clinical relevance of the Merit-based Incentive Payment System (MIPS), and more than 70% found MIPS scoring to be very or extremely complex. Despite this, according to CMS estimates in the recent calendar year (CY) 2018 Quality Payment Program (QPP) final rule, less than 71,000 clinicians are expected to participate in the QPP next year as participants in Advanced APMs, compared to 621,700 that will remain in MIPS. Clearly, there is not a lack of desire to participate in Advanced APMs.

The problem is that in the current market, there simply aren't enough of a variety of APMs to accommodate clinicians in different practice sizes, specialties and geographic areas. This year, there are only seven Medicare models that qualify as Advanced APMs. While the addition of Track 1+ next year is promising, the Comprehensive ESRD Care and Oncology Care Models are

[1] www.mgma.org/regrelief

not soliciting new applicants so in a way the opportunities to participate in Advanced APMs are decreasing, the opposite direction we want to be heading.

MGMA agrees with CMS that the APM pathway is a promising door to value-based reimbursement without imposing undue administrative burden by emphasizing flexibility and provider choice over one-size-fits-all reporting. We share CMMI's goal of expediting the process for providers to participate in Advanced APMs and believe the most important steps to achieving this are: 1) more appropriately defining qualifying risk, 2) more effectively leveraging and supporting APM development by external payers, and 3) expediently developing a wide range of diverse APM options that vary in structure, design, and approach.

MGMA supports CMS' recent proposal to scale back or eliminate mandatory participation in several payment models because we agree with this Administration that requiring participation in APMs violates the foundational principles of flexibility and innovation and places an undue burden on healthcare practices and systems. However, we agree with the agency that these models have potential as voluntary models given some refinements and we urge CMMI to implement these voluntary replacement models as expediently as possible so clinicians who were planning to participate in these models do not see their efforts go wasted and more clinicians have an opportunity to qualify as participants in Advanced APMs in 2018.

We would also like to draw attention to the impending termination of Bundled Payments for Care Initiative and are encouraged by comments made during CMMI panel session at the Oct. 30 Health Care Payment & Learning Action Network (LAN) Summit that they "are sensitive to creating more opportunities through that" model. We urge CMS to finalize these changes as expediently as possible so as not to impede ongoing or future participation in these initiatives. We further ask CMMI to consider adding new tracks with CEHRT and quality requirements so that this promising initiative may qualify as an Advanced APM in the future.

Expanding the definition of "nominal" risk

CMS has inhibited the APM pathway from achieving its true potential with its overly stringent approach to defining "nominal" risk that far surpasses Congressional intent. To date, CMS has not clarified how it mathematically arrived at its current 8% revenue-based and 4% financial risk standards, reiterating simply that it feels the current thresholds are appropriate. We disagree that these stringent percentage thresholds constitute "nominal" risk. If this Administration truly intends to rapidly increase performance in Advanced APMs, one of the simplest ways to do this is to take another look at why so many of its own models do not qualify.

Importantly- this risk standard would be a minimum. Lowering the standard would in no way commit the agency to exclusively designing models that meet this minimum standard, but it would provide it with more latitude to design models in the future that would have otherwise not been able to exist. These lower-risk models could especially appeal small and rural practices that are often to not have the financial reserves to support taking on higher levels of risk. Higher risk models already have an inherent incentive- more reward. It would defy logic for a practice that was performing well in an Advanced APM with higher levels of risk and reward to defer to a lower level, so lowering the minimum qualifying risk threshold would not reduce existing

participation in higher risk models and would therefore be no less effective in reducing expenditures than the current single standard. There is no need to set the floor itself unnecessarily high so that it prevents models from qualifying as Advanced APMs. In doing so, CMS only undercuts its goal of increasing voluntary participation in Advanced APMs.

Furthermore, there are a number of financial risks inherent to joining or starting an APM Entity that are currently in no way accounted for in the current definition of risk, despite being a very real financial hurdle for practices. A 2014 study by the National Association of ACOs found that on average, ACOs incur $2 million on average, up to as high as $6.7 million in start-up costs during their first year of operation alone.[2] Starting a new APM Entity requires significant staff training, the purchasing of information technology systems, care coordination expenses and a wide range of other expenses. To not factor these expenses into the calculation of risk defies logic and impedes thousands of APMs from qualifying as Advanced APMs. While we respect CMS' point that these investments may be "difficult to quantify" we do not think this reason alone justifies neglecting to count millions of dollars in financial risk. We are not asking that CMMI give APM Entities a blank check, we are merely asking the agency factor these very real financial costs of starting an APM into the risk equation, pending appropriate attestations and supporting documentation.

Lifting unnecessary restrictions

CMS inflicts upon itself a number of restrictive qualifying criteria for certain APMs that are not statutorily required and only serve to undercut participation in Advanced APMs. One such example is the artificial size and specialty restrictions on medical home models (MHMs). There is no reason Advanced APM MHMs should be restricted to primary care clinicians and services as there is no language in MACRA that specifically restricts specialty models from qualifying as MHMs. Furthermore, specialty models qualify as MHMs for purposes of MIPS and it is inconsistent to award these models with MHM in one pathway of the QPP, but not the other.

Despite around one out of every three Medicare beneficiaries now being enrolled in a Medicare Advantage (MA) plan[3], CMS previously neglected to count MA services toward the Medicare Qualified Participant (QP) threshold. MGMA was very encouraged by CMS' comments in the QY 2018 QPP final rule that it plans to explore demonstration projects in which MA payment arrangements would be toward QP determinations under the Medicare Option and that this would occur as soon as next year. However, no formal policies were specifically finalized in the rule. We urge CMS to expediently formalize these policies and to reiterate our position that there is no reason MA services should not be counted toward the Medicare threshold, as this is in no way prohibited under the MACRA statute.

Flexibility and choice

The single most important factor that distinguishes the APM pathway from MIPS is that APMs are intended to offer providers flexibility and choice. It holds clinicians accountable for patient outcomes and cost performance, but rather than ordering clinicians how to do their jobs with

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[2] https://naacos.memberclicks.net/assets/docs/pdf/acosurveyfinal012114.pdf
[3] https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/

generic, check-the-box reporting metrics, it frees clinicians to use their medical expertise to determine how to most effectively deliver high-value, low-cost care to a diverse patient population with unique characteristics and needs. Unfortunately, the current lack of available APM options, particularly in various specialties, has severely limited this track's ability to achieve its true potential.

MIPS' one-size-fits-all, primary-care centric approach cannot effectively engage providers in a range of specialties, practice sizes, and geographic locations, which is exactly why it is so important to develop a much broader range of APMs that have unique designs and are suited for different needs. Bundled payment models for instance show promise and are one of the few types of APMs that engage providers in certain specialties, but they are not appropriate for all care settings. Population-based models on the other hand take a more universal approach and implement changes on a larger scale, but often yield slower, more gradual results. All models come with positives and drawbacks and no single model be appropriate across all care settings, patient conditions or specialty types, but that is why there is such a need to produce a larger variety of Advanced APM options, particularly in clinical specialties.

Development of specialty models

We appreciate CMS' expressed interest in expanding the availability of qualifying physician specialty Advanced APMs, which is an area ripe for growth in Advanced APM participation. One of the most common criticisms we hear about MIPS is that it is primary care focused and does not adequately represent all specialties. APMs present a huge opportunity for specialists to join models that afford them more flexibility and better suit their unique needs while supporting CMS' goal of transitioning to value-based reimbursement. Early specialty-focused APMs have shown a lot of promise both in terms of savings to Medicare and properly aligning incentives to encourage continued participation. The Comprehensive ESRD Care Model for instance yielded a nearly $24 million net savings to Medicare last year and all but one were able to generate shared savings payments.

Despite promising performance from existing specialty models, to date there are only three specialty-focused APMs that qualify as Advanced APMs. The lack of available specialty focused Advanced APMs is perhaps the single largest obstacle to increased participation in Advanced APMs. Medicare bundled payment models and episode-based payment models have both shown promise for specialties and we encourage further development in these areas. The Physician-Focused Payment Model Technical Advisory Committee (PTAC) is currently considering numerous specialty-specific models and we urge CMS to work with them to expedite testing and implementation of new specialty APMs as quickly as possible.

Waiver Authority

CMS' payment and legal waiver authority remains one of its most powerful tools in helping APMs to achieve their goal of delivering value-based care through care coordination without fear of running into legal or regulatory liability concerns, particularly in the fraud and abuse realm. Using waivers to remove these unnecessary hurdles to care coordination is also a powerful incentive for practices and clinicians to participate in APMs. Medicare Shared Savings Program

(MSSP) participants regularly relay to us the value of Skilled Nursing Facility (SNF) 3-day rule anti-kickback waivers and how both allow them to coordinate care and make care decisions that are in the best interest of the patient without running into bureaucratic red tape. As more APMs are developed, we urge CMS to consider issuing broad, consistent waivers across models to ensure consistency and simplicity, particularly as these models may overlap and all center on a common premise of incentivizing care communication and taking financial accountability for a patient or episode of care and could therefore all benefit from the same waivers. Specifically, we urge CMMI to issue waivers in the following areas (though not restricted to these areas): SNF 3-day payment rule, anti-kickback rules, post-acute care payment rules, and telehealth and home health service billing requirements.

Patient incentives

In the current fee for service environment, there is an inherent mismatch between reimbursement and high-value services. Doctors are not incentivized to engage beneficiaries in their own care decisions. Likewise, beneficiaries, particularly those with robust insurance, have little skin in the game when it comes to feeling the true cost of their medical treatments, which leads to overutilization of expensive services. Designing models in such a way that both reward providers for engaging patients more regularly and actively in decision making about their care and at the same time, appropriately incentivizes patients to consider cost when it comes to their treatment options has real potential to yield major cost savings.

Structuring patient copays to prioritize high value services is an excellent example of a simple, straight-forward strategy to increase provider and beneficiary interaction to drive better health outcomes and lower costs. We have heard from our members that when it comes to Chronic Care Management (CCM) services for instance, patients are discouraged from taking advantage of this high-value service due to the copay. CMS should use its waiver authority to waive patient copays for CCM and other high-value services that are proven to have positive downstream cost effects through coordinating care better, improving patient outcomes, and ultimately keeping patients out of the emergency room. This strategy could be especially impactful in models that manage patients who suffer from chronic conditions, where patients may sense something is wrong but because of visit copays take the “wait and see” approach, causing their condition to worsen. Removing this unnecessary impediment to patient and provider interaction is a small step that could yield impressive results. Regular appointments allow providers to more closely monitor patients and spot complications before they worsen, preventing more expensive downstream costs, and also establishing a more regular, wellness-based relationship between clinician and patient often encourages the patient to contact the provider first before resorting to more drastic, expensive options such as calling an ambulance.

A number of CMMI models are built on the strategy of incentivizing providers to reduce costs by allowing them to share in a portion of the savings they generate. Private payers have begun extending this strategy to patients, and we encourage CMMI to follow suit. Offering patients an opportunity to share in savings for choosing a less expensive treatment plan is an effective strategy that can generate almost immediate savings, and can easily be incorporated to the design of numerous ongoing and new models. Provided certain safeguards are put in place to ensure

patients are not incentivized to select less effective treatment plans, this could be a winning, cost-effective strategy for all parties involved.

Leverage private sector development

The private sector has championed CMS' goal of driving value-based reimbursement by investing a substantial amount of resources into developing and implementing their own network of APMs. In many cases these mirror CMS models, but private payers are also testing new, innovative design strategies. Up to this point, CMMI has taken an insulated, top-down approach to developing their own payment models rather than capitalizing on ongoing progress in the private sector. We urge the agency to reverse this approach and to take advantage of the work that has already been done in the private sector and look to adapt some of these models for the Medicare population. This will expedite the process for getting new Advanced APMs on the market, synchronize and streamline APM objectives and measures across payer models and save the agency millions in research and development investment costs in the process.

The Physician Focused Payment Model (PFPM) Technical Advisory Committee (PTAC)

The PTAC was specifically created under MACRA to support CMS and facilitate the development and implementation of new PFPMs. Up to this point, the work between these two bodies has unfortunately been largely siloed and resulted in no new PFPMs being approved to date. At a recent hearing before the House Energy and Commerce Committee, there was visible frustration from the PTAC witnesses over the lack of direction from CMS and concern that their work up to this point has been in vain. MGMA understands that as with any new process there is a learning curve, and we appreciate the substantive insights that CMS provided in its written responses to the first three models recommended by the PTAC. However, we feel that the efficiency and productivity of this process could be exponentially improved with regular, ongoing communication and support between CMS, PTAC, and model developers throughout the PFPM development, application and approval process. All three parties share the same goal of getting more PFPMs on the market and ideally approved as Advanced APMs. For this process to be as effective as it can, CMS should share its insights throughout the PFPM development process to help model developers and PTAC understand what the agency is looking for and what design features should be fleshed out or altered before arriving at the finish line only to realize they have fallen short in one or more criterion.

Even if CMMI does allow developers the opportunity to go back and "address some design concerns" before making a final determination as it did with the American College of Surgeons-Brandeis Advanced APM, some developers may not have the ability to go back and continue adjusting various features. Developing original proposals already requires a substantial investment of time and money. Changing even one feature could require the developers to rerun all the calculations and financial simulations, and developers may run out of resources, patience or both for what at this point has proven to be a fruitless exercise, meaning that all that work and all those resources would have no APM to show for it.

With the PTAC and private sector taking the lion's share of the work in the PFPM development process, lending more support throughout the process is one of the most efficient ways CMMI

can spend its time and resources to create maximum impact in the form of new, qualifying APMs. Failing to do may easily result in reduced morale and a slowdown of proposals being submitted for new PFPMs, undercutting CMS' goal of developing more such models.

Data sharing

Another critical and inexpensive way CMMI could better support development of APMs in the private sector while at the same time increasing participation, better informing design and improving the overall performance of its own models is through transparent data sharing.

One of the primary suggestions private payer APM developers reiterate is the need for necessary claims data to model and develop new APMs. CMS not only controls the single largest claims dataset, it also has the unique ability to bring other payers to the table. Despite this, numerous payers have attested that CMS is reluctant to share its data with participants or other payers in the interest of APM development. At the LAN summit last month, multiple private payers emphasized how critical the government's role is in the success of private sector APM development, both in terms of facilitating as link between payers for cooperation on models, and providing the robust data and support that only CMS is uniquely capable of providing. Speaking on a panel about CMMI multi-payer perspective, a Blue Cross Blue Shield representative stated, "data sharing is one of the biggest obstacles to creating APMs." During a separate CMMI update session, an audience member added: "information sharing would immensely help states and model developers." By withholding critical data from private sector developers, CMS is inhibiting the future development of PFPMs that could eventually be scaled to meet the needs of the Medicare population.

By not sharing data with current and potential future participants in Advanced APMs, CMS is also inhibiting the growth and success of its own models. Restructuring a practice's reimbursement structure is no small risk or logistical undertaking, and unless the practice feels confident they have the necessary support and data to effectively evaluate the risk and make an informed decision, many practices simply won't be able to justify taking the leap. This would disproportionately prevent smaller, independent practices from joining APMs.

CMS is not fully transparent even with current participants of its own models. MSSP participants receive information about their own performance but no one outside of CMMI gets MSSP-wide performance data to a level of detail that allows them to replicate financial benchmark or settlement data. This undercuts the credibility and transparency of the MSSP and handicaps independent researchers from producing meaningful findings that could help to improve the effectiveness of the program. MGMA urges CMS to publicly release all data related to performance in current APMs, work with external payers to provide any data they need to facilitate their own model development to the maximum extent possible without sacrificing patient privacy, and to facilitate the exchanging of data between payers, including developing a new technology platform to this end.

Front-end investment and support

Starting or joining an APM requires significant up-front investments in staff training, new technologies, new care coordination services, among other costs. Many practices, particularly those that are small and/or rural, do not have the financial reserves to join an APM, despite having interest. CMS has an opportunity to step in and have a direct, tangible impact on APM participation and success. The MSSP advance payment and ACO Investment Model (AIM) initiatives are great examples of what can happen when CMS provides APM Entities with the front-end financial support they need. Out of 432 ACOs in 2016, 63 were enrolled in one of these two funding initiatives, without which their participation may not have been possible. Approximately 70% beat their financial benchmarks, verses 56% of MSSP ACOs who did not receive any form of advance funding. Moreover, approximately eight out of every ten ACOs enrolled in the AIM have at least 65% of their delivery sites located in rural areas.

The significance of logistical support also cannot be understated. We applaud the agency for its dedicated technical assistance and targeted outreach and resources to help small and rural practices succeed in MIPS and urge the agency to extend similar logistical support to small and rural practices to enhance their participation in APMs. We urge CMS to look for new ways to expand its logistical and financial support of individual APM Entities, particularly in rural areas, which may include but is not limited to advance payments, providing technology necessary for participation, and offering dedicated logistical support and targeted educational outreach.

State-based, local, and Medicaid-focused models

States could be a critical incubator for new innovative care models, particularly those that account for regional market factors, but they cannot do it without the support of CMMI throughout the development process, including staff on hand to answer questions and assist in the development, providing data critical to modeling the potential success of new models and providing financial and technological support to help get new models off the ground.

Multi-payer models

A common theme we have heard from our own membership as well as various panels on successful APM ventures is the importance of engaging multiple payers in a single model. There are proven benefits for all parties from an economies of scale standpoint. An increased beneficiary population means APM participants are less vulnerable to the influence of external variables on their patient health outcomes and would be evaluated more accurately on their performance. Additionally, aligning monetary incentives across payers would mean participants have a higher incentive to invest money and resources to ensure success in the model. Payers and participants would both benefit from shared data, shared cost of developing new technologies and procedures, and the insights that a model with a large patient population is able to provide about public health outcomes and the development of new APMs of similar design or focus.

By working in silos, each payer creates its own set of reporting requirements and specific outcomes goals to evaluate progress on the same conditions. This leaves providers to invest even more administrative time and effort to untangle the various requirements and comply with

separate reporting criteria and ultimately hinders their ability to succeed because they are forced to divide resources and attention. If all the payers share the common goal of driving down costs while delivering high-value care, there is no reason they should not work together with providers toward this goal. A panelist on multi-payer perspectives at the LAN Summit stated that alignment across payers would “drastically reduce the burden” on clinicians and MGMA could not agree more.

CMS Oncology Care Model has generated positive feedback across the industry largely because it is a multi-payer model. We urge CMS to continue building on these successes by expediently developing more multi-payer models.

Risk adjustment

The current system of relying primarily on the Hierarchical Condition Categories (HCCs) is overly simplistic and fails to account for the wide range of sociodemographic factors that have been linked with patient outcomes. In the current payment environment where the reimbursement of practices and individual clinicians is increasingly tied performance on cost and quality metrics, it is paramount we get risk adjustment right. Without proper risk adjustment, cost and quality metrics could be tainted by any number of confounding variables, which could lead to unfairly penalizing clinicians for treating high-risk patient populations. If the path to APMs gets too far along without properly risk adjusting, we could start to see scenarios where high-risk patients are systematically turned away from health systems for fear of the impact it will have on their performance metrics and therefore their financial bottom line. We encourage CMS to invest substantial time and resources in testing different risk adjustment strategies across the spectrum of current and future models before it gets to this point, keeping in mind that risk-setting protocols should not be one-size-fits-all for all APMs.

Program integrity

Program integrity is naturally an important concern for both individual APMs and the Medicare program at large. However, given the application process to join an APM is already arduous, we ask CMS to weigh the tradeoffs of further increasing the amount of paperwork and documentation required on the front-end for all APM applicants for the express purpose of catching a handful of bad actors with the resulting increase in provider burden that may discourage participation in Advanced APMs. We applaud CMS for its decision to eliminate some of the up-front documentation required during the MSSP initial application and skilled nursing facility (SNF) 3-day waiver application processes in the recently finalized 2018 Physician Fee Schedule and encourage the agency to continue moving this direction and look for opportunities to minimize provider burden during the application process. As more APMs are developed and overlap with one another, it will be in CMS’ own interest to keep program integrity paperwork to a minimum and streamline requirements across programs. MGMA also reminds CMS that with all its current models, the agency reserves the right to impose strict, sweeping sanctions on APM Entities who violate program integrity agreements, and this has proven to be an effective approach to date as there have been limited cases of program integrity violations. We are encouraged by CMS’ demonstrated awareness of this inherent dichotomy by posing this question and encourage the agency to weigh the benefits of potentially catching a small handful of bad

actors against the possible consequences of alienating future participants and hindering the success of the APM.

Stakeholder input

One of the key ingredients to the development of successful models is active and frequent stakeholder feedback. Unfortunately, in the past CMMI has engaged in a limited degree of transparency and stakeholder engagement as new top-down models were being developed, which we feel in some cases had a direct, negative impact on early financial performance. For example, since its inception the MSSP benchmarks has been criticized for failing to account for regional spending, so in the 2016 Final MSSP Rule, CMS addressed this stakeholder concern by incorporating an element of regional spending into the benchmarks. Had CMS taken more opportunities to incorporate stakeholder feedback in earlier stages of model design and development, as opposed to after the model was already finalized, benchmarking could have been more accurate from the start, which likely would have had a meaningful, positive impact on the early financial success of the MSSP (which to date has yielded mixed results) and could have therefore generated more provider interest and participation.

We are pleased CMS is taking this opportunity to reassess and solicit stakeholder input regarding the future direction of CMMI and has signaled its intent to create more opportunities for stakeholder engagement in the future. We share CMS' goals of continuously striving to improve the design of current Advanced APMs and to expedite the creation and smooth implementation of new models. Our members facilitate the daily implementation of these new payment models and bring a valuable perspective that we look forward to sharing with CMMI through feature opportunities for stakeholder engagement.

Conclusion

Thank you for this opportunity to comment on the future direction of CMMI. We hope to serve as an ongoing resource in future discussions as we work together to increase the number and variety of available Advanced APMs and drive overall participation in these models as a critical component of the transition to value-based reimbursement. Please don't hesitate to contact Suzanne Falk with any additional questions at sfalk@mgma.org or 202.293.3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs
Medical Group Management Association