The Voice of Accountable Physician Groups

October 13, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5524-P,
P.O. Box 8013,
Baltimore, MD 21244-1850

Re: Medicare Program; Cancellation of Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model (CMS-5524-P)

Dear Administrator Verma,

We appreciate the opportunity to comment on the agency's proposals to modify the Innovation Center's mandatory bundled payment initiatives.

CAPG represents nearly 300 multi-specialty physician organizations across 44 states, Washington, D.C. and Puerto Rico. CAPG members participate in value-based payment models across all of Medicare, and have successfully operated under risk-based payment models for over two decades. We represent physician groups along the spectrum of value-based payment initiatives, including those participating in bundled payment initiatives with Medicare, Medicare Advantage, and commercial payers, high-performing Medicare Shared Savings Programs (MSSP) and Next Generation Accountable Care Organizations (ACO), as well as physician groups who are capitated by payers including Medicare Advantage plans, Medicaid managed care plans, and commercial plans.

These alternative payment models (APMs) avoid incentives for high utilization associated with fee-for-service, and instead align incentives for physicians to innovate and provide the best care to improve the health of entire populations, particularly seniors. Our members' value-based pay arrangements create incentives for (1) a team-based approach that emphasizes primary care; (2) physician organizations to provide the right care at the right time in the most appropriate setting; and (3) a care team that addresses the patient's total care needs, including mental and behavioral health and the home environment.

Further incentives for health care providers to move away from traditional fee-for-service payment arrangements towards APMs that improve care and lower costs to both patients are critical. CAPG seeks to accelerate both the creation of new APMs and the development of strong incentives for physicians to move into these models.

1501 M Street, NW
Suite 640
Washington, DC 20005
Telephone: 202-770-1869
www.capg.org

To summarize, CMS proposes (1) cancelling Episode Payment Models (EPMs); (2) cancelling the Cardiac Rehabilitation (CR) incentive payment model; and (3) limiting the scope of mandatory testing of Comprehensive Care for Joint Replacement (CJR) model (reducing the number of mandatory participating MSAs from 67 to 34).[1]

To summarize our comments, while we understand and support the need for voluntary, flexible participation in new payment and delivery models, we remain concerned that scaling back bundled payment models decreases opportunities for providers to participate in advanced APMs. We recommend that CMS swiftly implement Medicare Advantage alternative payment models to allow sophisticated, risk-bearing physician groups to obtain advanced APM status.

Our detailed comments on the proposed rule are provided below.

I. Bundled payment models offer an important on-ramp to value-based care.

We agree with CMS that bundled payment models offer opportunities to redesign care processes to improve care and reduce costs. We offer two specific examples from *CAPG's Guide to Alternative Payment Models* that highlight our members' success with bundled payments in different programs:

- Providence Health & Services, has successfully navigated bundled payment models by working with both commercial and Medicare Advantage (MA) sponsored plans to develop a bundled price for episodes of care, and sharing in the financial savings garnered by use of this model. Because of this program, Providence has seen the length of hospital stays decreased by 50 percent for commercial patients and 32 percent for Medicare patients.[2]
- Catholic Health Initiatives (CHI) participating in Medicare's Bundled Payment for Care Improvement (BPCI) initiative saw a reduction in readmission rates by 46 percent and skilled nursing facility utilization by 45 percent.[3]

Both case study participants highlight that they are using bundled payment models as a foundation to move to population health models. CAPG is committed to pursuing population-based capitated and other budget based payments in traditional Medicare and MA. However, we recognize that not every physician across the country is ready to enter a capitated arrangement today. We appreciate CMS's indication that the Innovation Center will continue develop new voluntary bundled payment models in CY 2018 that would be designed to meet the criteria to be an advanced APM.[4] We reiterate our view that it is important to continue to view bundled payment models as a first step toward advanced APMs, not as a final destination for delivery reform.

[1] Medicare Program; Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model 82 Fed. Reg. 39,310 (Aug. 17, 2017) [Proposed Rule].
[2] CAPG's Guide to Alternative Payment Models 2017, available at http://capg.org/index.aspx?page=340 (accessed October 9, 2017).
[3] CAPG's Guide to Alternative Payment Models 2016, available at http://www.capg.org/index.aspx?page=382 (accessed October 9, 2017).
[4] Proposed Rule, at 39,313.

II. This proposal underscores the need for CMS to count Medicare Advantage (MA) risk contracts as MACRA APMs.

While we understand the agency's interest in scaling back the specific models mentioned in this rule, we are dismayed with what we view as insufficient APM options for physicians and physician groups that want to participate in MACRA's APM track. The handful of models currently available do not meet the needs of physician groups across the country. As a result, many sophisticated organizations will end up stuck in the MIPS track, even if they are capitated in Medicare Advantage, commercial, and Medicaid managed care contracts. Further exacerbating the MACRA problem for high performing physician groups, many clinicians have been excluded from MIPS, substantially reducing the potential for bonus payments for high performers in MIPS. Thus, high performing physician organizations are losing out on opportunities in MACRA's MIPS and APM track.

We call on CMS to expediently expand the number of available advanced APM options. Specifically, **CMS should act in its forthcoming rules to create a qualifying advanced APM for MA for the 2017 payment year, 2019 performance year**. Under current regulations, physicians receive no MACRA credit for their MA risk contracts, even if they are taking substantially more risk in MA than any of the traditional Medicare models currently offer. We think this policy is misguided. MA is the best available platform for proliferating successful APMs. We urge CMS to implement an MA APM demonstration in CY 2018 to allow risk-bearing physician groups their opportunity to be recognized as advanced APM participants. For additional information, please refer to our comments on the MACRA Quality Payment Program 2018 proposed rule.

III. Conclusion

Thank you for the opportunity to comment on this Proposed Rule and for your consideration of our recommendations. We look forward to collaborating with CMS on how changes to physician payment can improve quality and lower costs for America's seniors. For questions about these comments, please contact Mara McDermott, Vice President of Federal Affairs (mmcdermott@capg.org).

Sincerely,

Donald H. Crane
President & CEO, CAPG