AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20210

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:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am pleased to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule that would cancel three Episode Payment Models (EPMs) and the Cardiac Rehabilitation (CR) incentive payment model, and revise certain aspects of the Comprehensive Care for Joint Replacement (CJR) model.

The AMA strongly supports CMS' proposal to cancel the three new EPMs and the CR incentive payment model in order to improve and more fully develop aspects of these models prior to the start of their implementation. We would welcome the opportunity to work with CMS as it explores further development of these models.

In addition, the AMA also supports CMS' proposed changes to the CJR model including:

- Allowing hospitals to voluntarily participate in the model;
- Establishing Practice Expense (PE) Relative Value Units (RVUs) for telehealth codes furnished under the CJR telehealth waiver; and
- Expanding the Affiliated Provider List to include additional physicians and non-physician practitioners.

Finally, as CMS continues to develop new EPMs and other Advanced Alternate Payment Models (APMs), we encourage the agency to focus on the following types of models:

- Models that are developed by and led by physicians;
- Models that can be undertaken jointly by teams of different providers, including hospitals, physicians, and post-acute care facilities;

- Models that include improved risk adjustment methodologies developed with clinical input and stakeholder feedback from medical specialties that have experience with the difficult risks facing patients who will be treated in these new payment models; and
- Models that incorporate appropriate and effective quality measures into new payment models.

Cancellation of EPMs and CR Model

The AMA strongly supports CMS' proposal to cancel the bundled payment models for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and surgical hip/femur fracture treatment (SHFFT) episodes, and a CR incentive payment model. We support CMS' cancellation of the EPMs and CR model in response to comments from numerous stakeholders, including the AMA, that the new models may increase providers' administrative burden. The AMA and other stakeholders highlighted concerns with the models' design, including participation requirements, data, pricing, quality measures, episode length, nursing facility waivers, beneficiary exclusion and notification requirements, and repayment issues.

The AMA specifically appreciates CMS' acknowledgement in the proposed rule that many stakeholders, including the AMA, urged CMS to allow participants in the CABG model to use a CABG composite score developed by the Society of Thoracic Surgeons (STS) rather than the all-cause mortality measures. We continue to urge CMS to work with medical specialty societies in developing appropriate risk adjustment methodologies for new payment models.

We agree that certain aspects of the design of the EPMs and CR incentive payment model should be improved and more fully developed prior to the start of the models, and that moving forward with the implementation of the models at this time would not be in the best interest of providers or beneficiaries. The AMA would appreciate the opportunity to work with CMS if it decides to revisit the models in the future.

The AMA also supports CMS' proposal in the rule to build on the Bundled Payment for Care Improvement (BPCI) initiative by developing new voluntary bundled payment models during 2018 that would meet the criteria to be Advanced APMs. The development of more Advanced APM models structured similarly to the BPCI initiative would allow physicians the opportunity to participate in a greater variety of bundled payment models during 2018.

CJR Model Changes

The AMA supports many of the changes CMS proposes to make to the CJR model. First, we appreciate CMS' proposal to allow hospitals in certain Metropolitan Statistical Areas to elect to voluntarily participate in the CJR model. If a team of physicians and other providers believe they can use the flexibility and resources available in a bundled payment program to improve patient care, then they will have a strong incentive to voluntarily participate in a new model. If they do not believe they can improve care by participating in the model, and particularly if they believe these payment models would compromise their ability to deliver high quality care, CMS should not force them to participate. The AMA has repeatedly noted that the large and diverse population that has entered into agreements to participate in the BPCI initiative is evidence of the interest and willingness of physicians and other healthcare professionals to voluntarily implement properly designed new payment models. The AMA

also supports the exclusion of low-volume and rural hospitals from mandatory participation in the CJR model.

In addition, the AMA is strongly supportive of CMS' proposed adjustment to the CJR telehealth Healthcare Common Procedure Coding System (HCPCS) codes to include the facility PE values. CMS previously established nine HCPCS G-codes to report home telehealth evaluation and management (E/M) visits furnished under the CJR telehealth waiver. CMS did not include the PE RVUs of the comparable office and other outpatient E/M visit codes in the payment rate for these services, based on CMS' belief that the practice expenses incurred to furnish these services were marginal. The AMA previously urged CMS to seek information from organizations representing the physicians who perform these services about the expenses involved in their delivery instead of basing payment rates on an assumption that providers incur no practice expenses.

We applaud CMS' acknowledgement of stakeholders' feedback that there are additional costs related to the delivery of telehealth services under the CJR model such as maintenance of telecommunications equipment, software, and security. We strongly support CMS' proposal to use the facility PE RVUs for the analogous in-person services in the CJR telehealth codes.

Finally, we support CMS' proposal to expand the Affiliated Provider list for the CJR model. Stakeholders had previously urged CMS to include on the Affiliated Provider List physicians and non-physician practitioners who do not have financial arrangement under the CJR model, but who are affiliated with and support the Advanced APM Entity. Therefore, we support CMS' proposal to allow physicians and non-physician providers who have a contractual relationship with the participant hospital, based at least in part on supporting the participating hospitals' quality or cost goals under the CJR model during the period of the performance year specified by CMS, to be added to a clinician engagement list. The clinician engagement list would be considered an Affiliated Provider List to identify clinicians who would be considered a Qualifying Participant though the Advanced APM track of the CJR model.

Additional Considerations

As we have stated in previous comment letters, the AMA urges CMS to consider a few key issues when developing future EPMs.

Physician-Led EPMs

We continue to urge CMS to support physician leadership in redesigning care delivery. Physician leadership is essential for successful implementation of any payment model intended to support a comprehensive approach to care for Medicare patients. Only physicians can make the determination as to what types of care could effectively address patients' needs and in which settings those care services can be delivered safely and successfully. A bundled payment should be developed so physicians have leadership roles in designing the care delivery process and ensuring it achieves good patient outcomes without unnecessary costs. The physicians, facility, and other providers involved in the episode can then decide together what role the facility should play in the coordination and financing of the care.

Team-Based EPMs

The AMA also urges CMS to develop flexible episodes that allow physicians, hospitals, and post-acute care providers to organize themselves into different arrangements. As we have stated in previous comment letters, one of the most important accomplishments CMS has made through the Centers for

Medicare & Medicaid Innovation (CMMI) center is making multiple payment models available in the BPCI program for the same procedure or conditions. CMS should extend this flexibility to new alternative payment models it designs going forward.

In addition, medical specialty societies are developing a number of episode-based APMs that could support team-based management of patients' conditions and procedures in ways that the current Physician Fee Schedule cannot. For example, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) has recommended that CMS test an episode grouper model developed by the American College of Surgeons and a model for specialist management of chronic diseases developed by a gastroenterologist who is active in the American Gastroenterological Association. Specialty societies are also working on models for better managing rheumatoid arthritis, serious illnesses requiring palliative care, diabetes, renal disease, addiction and other conditions. As it moves forward, CMS should work with the PTAC and specialty societies to develop voluntary, episode-based APMs.

Risk Adjustment

While we acknowledge that it is difficult to risk adjust when patients have multiple chronic conditions that interact with one another, we continue to urge CMS to work with physician organizations to improve risk adjustment methodologies in new payment models it develops. One way CMS could improve risk adjustment in new episode payment models is to work with the clinician community to establish as much homogeneity as possible among beneficiaries. For example, in CMS' previously proposed AMI model, the AMA urged CMS to only include beneficiaries that have AMI as their primary diagnosis. Limiting inclusion to the most clinically similar subset of patients allows for meaningful comparison among patients and provides CMS the opportunity to clearly evaluate the impact of episode payment models on patient care and outcomes. The AMA believes that medical specialty societies and CMS must continue to work together to ensure new payment models include effective risk adjustment methodologies and do not discourage treatment of the sickest patients.

Quality Metrics

CMS should consider its approach to quality metrics in new episode payment models. For example, the AMA previously encouraged CMS to use the STS CABG Composite Score to measure quality within the CABG model. The composite score is a single number that summarizes all available information about the quality of care delivered by a single provider. The composite score is comprehensive; National Quality Forum endorsed, already used and voluntarily reported by the majority of thoracic surgeons, and mitigates sample size concerns. CMS should work with specialty societies as future episode payment models are developed to determine the best way to measure quality within each episode.

The AMA appreciates the opportunity to provide comments and thanks CMS for considering our views. If you should have any questions regarding this letter, please contact Margaret Garikes, Vice President for Federal Affairs, at margaret.garikes@ama-assn.org, or 202-789-7409.

Sincerely,

James L. Madara, MD