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November 19, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 314G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS Request for Information on Innovation Center New Direction

Dear Administrator Verma:

Thank you for recognizing the need to establish a new direction for the Center for Medicare and Medicaid Innovation and for soliciting input to determine that direction. Although a number of innovative projects have been supported by CMMI since its creation seven years ago, the overall results in creating effective Alternative Payment Models have been disappointing:

- Although many patients have benefited from enhanced and improved services, most of the Alternative Payment Models CMMI has implemented have not resulted in significant savings.
- Only one of the models tested by CMMI has been expanded nationally (the Medicare Diabetes Prevention Program), and this model is not considered an "Advanced Alternative Payment Model" under CMS regulations.
- As of the end of 2017, only five payment models created by CMMI met the requirements that would enable physicians to receive the higher payments authorized by Congress under MACRA. Most of the physicians who are participating in MACRA-eligible Alternative Payment Models are part of Accountable Care Organizations in the Medicare Shared Savings Program, not part of payment models created by CMMI.
- One-third of the more than $5 billion spent by CMMI in its first six years was used for a variety of planning and technical assistance projects, not for Alternative Payment Models or projects that could serve as the basis for Alternative Payment Models.

The disappointingly slow progress in implementing successful Alternative Payment Models means that each year, millions of Medicare beneficiaries are being denied the opportunity to receive higher-quality care and the Medicare program is spending billions of dollars more than is necessary.

We urge that you make four fundamental changes in the way CMMI and CMS support innovations in Medicare payments that would address these problems and dramatically accelerate the implementation of successful Alternative Payment Models (APMs):

1. **Embrace a bottom-up approach to payment innovation at CMS:**
    - Commit to quickly implement all of the physician-focused Alternative Payment Models that are recommended by the Physician-Focused Payment Model Technical Advisory Committee.
    - If a group of providers and payers in a state or region have developed or implemented an innovative APM, agree to implement a similar approach to paying for the care of Medicare beneficiaries in that community so that the providers can have full multi-payer support.
2. **Create the capacity at CMS and its MACs to implement bundled payments and other Alternative Payment Models.**
3. **Use limited-scale testing to accelerate innovation.**
4. **Create a faster, more efficient approach for implementing APMs:**
    - Completely redesign the processes CMMI uses to test and implement alternative payment models in order to achieve the goals that are implicit in MACRA – every physician should have the opportunity to receive at least 25% of their revenues from well-designed alternative payment models in 2019, at least 50% of their revenues from APMs in 2021, and at least 75% of their revenues from APMs in 2023.
    - Establish specific milestones that are designed to implement as many alternative payment models as possible and as quickly as possible.

More detail on each of these recommendations is provided below.

1. Embrace a Bottom-Up Approach to Payment Innovation at CMS

In its first seven years of operation, CMMI has taken a primarily top-down approach to designing Alternative Payment Models (APMs). Although it has nominally encouraged submission of proposals for APMs by physicians and other stakeholders, CMMI has only been willing to test or implement APMs of its own design. Moreover, there has been a clear bias toward payment models focused on groups of patients on whom Medicare spends large amounts of money and toward payment models that are difficult for small physician practices and small hospitals to implement.

For example, the first physician-focused payment model recommended by the Physician-Focused Payment Model Technical Advisory Committee was Project Sonar, a payment model that was developed by an independent gastroenterology practice in order to support better care management for patients with inflammatory bowel disease. Despite the fact that the payment model had already been implemented with commercially-insured patients with support from Blue Cross Blue Shield of Illinois, despite the fact that it had resulted in better patient outcomes

and significant savings for the health plan, and despite the positive recommendation by PTAC, CMS declined to implement it, saying: "in lieu of testing the model as proposed…CMS [will] reach out to the Illinois Gastroenterology Group and SonarMD, LLC to involve them in HHS' development of specialty models. As HHS develops potential models in this area, we will consider the input and insights from this proposal." No indication was given as to when any such specialty models would be developed or implemented. Moreover, CMS suggested that spending associated with patients with inflammatory bowel disease was not large enough to warrant pursuing implementation of an alternative payment model to improve care for these patients, saying that "Patients with IBD accounted for only 1.25 percent of Medicare FFS spending."

In 2014, CMMI issued a Request for Information asking for input on the creation of specialty-specific payment models, and it convened several Technical Expert Panels to explore payment models in specialties such as cardiology, gastroenterology, neurology, and oncology. However, in the three years since then, CMMI has implemented only one APM – the Oncology Care Model – that was specifically designed for participation by small, non-primary care specialty physician practices.

In 2015, Congress recognized that CMMI had done too little to create Alternative Payment Models that were specifically designed for physicians. In the Medicare Access and CHIP Reauthorization Act (MACRA), Congress created a bottom-up approach that specifically welcomes APMs designed by physicians and other practitioners and that encourages development of APMs and delivery models that are feasible for small physician practices and small hospitals to implement. **CMS should embrace the process that Congress has created and commit to quickly implement all of the physician-focused Alternative Payment Models that are recommended by the Physician-Focused Payment Model Technical Advisory Committee.**

In addition, there are a number of communities across the country where physicians, hospitals, and other providers are working with patients, employers, health plans, and other purchasers to develop and implement alternative payment models to support high quality, more affordable care. However, it is difficult for these communities to successfully transform care delivery without participation by Medicare. Although CMMI has expressed a desire to support multi-payer APMs, the primary approach it has used to date has been to require local payers to conform to a structure CMMI defines, even if the payers and providers in a community have already implemented a different approach. Instead of the current top-down approach, **if a group of providers and payers in a state or region have developed or implemented an innovative APM, CMS should agree to implement a similar approach to paying for the care of Medicare beneficiaries in that community so that the providers can have full multi-payer support.** This was done in five states in 2011, when CMS agreed to participate in the Multi-Payer Advanced Primary Care Initiative, and a similar approach should be used in the future for APMs in specialty care and other areas.

2. Create the Capacity at CMS and its MACs to Implement Bundled Payments and Other Alternative Payment Models

Most of the large Alternative Payment Models created by CMMI – the Bundled Payments for Care Improvement (BPCI) model, the Comprehensive Care for Joint Replacement Model, the Comprehensive ESRD Model, the NextGen ACO Model, and the Pioneer ACO Model – follow the same basic formula:

- **No changes are made in the current fee for service structure.** In most CMMI APMs, physicians, hospitals, and other providers continue to be paid under standard Medicare payment systems. No payments are made for any new services, even if those new services would be necessary or highly desirable in improving patient care and reducing avoidable spending.
- **Additional payments are dependent on achieving "shared savings."** A year or more after services are delivered, the physicians, hospitals, or other providers in the APM may receive an additional payment (or be required to repay some of the payments they have already received) based on whether CMS determines that it spent less than it otherwise would have. This approach is essentially the same as CMS's pay-for-performance programs, except that the bonuses and penalties are proportional to the amount of money saved. This means that providers who already have high levels of performance receive no additional resources to sustain their operations, while providers who have had high rates of complications or who have overused expensive services can receive large bonuses for addressing those problems.

Shared savings models are attractive to payers because they are very simple to implement. In a shared savings model, the payer doesn't have to make any changes in the way it pays any providers for any of the services they deliver; all that is needed is for the payer to make a one-time retrospective comparison of actual vs. expected spending to determine whether the provider should receive a bonus or penalty.

However, what is simple for payers is problematic for providers and patients, since the shared savings model fails to ensure that participating providers will receive adequate or timely funding to support new high-value services that would benefit their patients. An even greater concern is that a shared savings program can financially reward a healthcare provider for failing to order or deliver a costly service that a patient needs, since the provider could receive a portion of the savings when fewer services are delivered.

In addition, while it is clearly easier for CMMI to pursue payment models that hold providers accountable for total Medicare spending, payment models based on total spending inappropriately place small providers and single-specialty providers at significant financial risk for things they cannot control and can discourage providers from treating patients with unusual or complex needs.

In contrast to the shared savings payment models CMS and CMMI have pursued, a good alternative payment model will have the following characteristics:

- **Adequate resources to support the services patients need.** Since the current fee-for-service system does not pay adequately or at all for many high-value services (e.g.,

communication among physicians to resolve a diagnosis or coordinate services, proactive outreach to patients to identify problems early, etc.), successful alternative payment models need to provide additional resources to deliver these services in order for providers to reduce the use of other, more expensive services.

- **Flexibility for providers to deliver the most appropriate services.** In a successful alternative payment model, a provider or team of providers would not be penalized financially for choosing the best combination of services for their patients.
- **Accountability for the aspects of quality and spending that the provider can control.** In return for adequate, flexible payments, a provider can accept accountability for improving quality and reducing costs, but the accountability needs to be focused on the types of outcomes and spending that the provider can control. In addition, both accountability measures and payment amounts need to be adjusted for differences in patient characteristics that affect outcomes and costs.

There is no single alternative payment model with these characteristics that will work for all types of patients and all types of healthcare providers. Different medical specialties treat different kinds of health problems, and the opportunities to improve quality and reduce costs will differ for the different types of health problems addressed by physicians within each specialty and subspecialty. Moreover, the care delivery changes that are needed to address these opportunities will also differ by specialty, as will the barriers in the current payment system that need to be overcome in order for physicians, hospitals, and other healthcare providers to redesign care delivery for their patients.

However, a relatively small number of alternative payment model structures will likely be able to enable most physician practices and other providers to address the vast majority of patient needs. The American Medical Association and CHQPR identified seven types of physician-focused Alternative Payment Models that can be used to address the most common types of opportunities and barriers that exist across all physician specialties. These are:

1. **Payment for a High-Value Service.** Under this APM, a physician practice could be paid for delivering one or more desirable services that are not currently billable, and in return, the practice would take accountability for controlling the use of other, avoidable services for its patients.
2. **Condition-Based Payment for Physician Services.** Under this APM, a physician practice would receive a bundled payment that provides the flexibility to use the diagnostic or treatment options that address a patient's condition most efficiently and effectively without concern that using lower-cost options would harm the operating margins of the practice.
3. **Multi-Physician Bundled Payment.** Under this APM, two or more physicians who are providing complementary diagnostic or treatment services to a patient would have the flexibility to redesign those services in ways that would enable high-quality care to be delivered as efficiently as possible.
4. **Physician-Facility Procedure Bundle.** This APM would allow a physician who delivers a procedure at a hospital or other facility to choose the most appropriate facility for the treatment and it would give the physician and facility the flexibility to deliver the procedure in the most efficient and high-quality way.

5. **Warrantied Payment for Physician Services.** This APM would give a physician practice the flexibility and accountability to deliver care with as few avoidable complications as possible.
6. **Episode Payment for a Procedure.** This APM would enable a physician who is delivering a particular procedure to work collaboratively with the other providers delivering services related to the procedure (e.g., the facility where the procedure is performed, other physicians who are involved in the procedure, physicians and facilities who are involved in the patient's recovery or in treating complications of the procedure, etc.) in order to improve outcomes and control the total spending associated with the procedure.
7. **Condition-Based Payment.** Under this APM, a physician practice would have the flexibility to use the diagnosis or treatment options that address a particular health condition (or combination of conditions) most efficiently and effectively and to work collaboratively with other providers who deliver services for the patient's condition in order to improve outcomes and control the total spending associated with care for the condition. Condition-based payments are the most patient-centered payment models and provide the greatest opportunities to improve outcomes and control spending.

Additional details on these Alternative Payment Models and examples of how they are being used are available in *A Guide to Physician-Focused Alternative Payment Models*, which is available at http://www.chqpr.org/downloads/Physician-FocusedAlternativePaymentModels.pdf.

CMS cannot currently implement true bundled payments because its current claims payment systems do not support them. Failing to make investments in the administrative systems needed to implement new payment models is penny-wise and pound-foolish, because the potential savings from better payment models will far exceed the costs of implementing them.

CMS and its Medicare Administrative Contractors (MACs) should quickly make any changes needed in Medicare claims payment and other administrative systems to support implementation of all seven of these alternative payment model structures. This would not only ensure that CMS can quickly implement a wide range of proposed APMs, but it would encourage physician practices, medical specialty societies, and others to design payment models in a common framework, which will reduce implementation costs for CMS.

In addition, **CMS should revise the definition of "financial risk" in the MACRA regulations for Advanced APMs to enable design of APMs that small physician practices can feasibly participate in.** In MACRA, Congress required that in order for a physician to be exempt from MIPS and to qualify for the bonus payments authorized by Congress, the alternative payment entity receiving the payment must bear "financial risk for monetary losses … that are in excess of a nominal amount." The risks incurred when a physician practice participates in an alternative payment model are a function of both the *costs that the practice incurs* to implement the model and the *revenues it receives under the model*. If the practice hires or pays for new staff to deliver services to patients under the alternative payment model, if it acquires new or different equipment to deliver services, or if it incurs increased administrative expenses to implement the alternative payment model, and if those expenses are not automatically or directly reimbursed by Medicare, then the practice is accepting financial risk for monetary losses. Therefore, CMS regulations defining the practice's risk should be revised to include consideration of the increased costs a practice incurs, not just increases in Medicare spending. CMS should also

lower the requirement that a practice pay CMS as much as 8% of its revenue when spending increases, since that represents *substantial* financial risk, not just "more than nominal risk."

Moreover, a physician practice that agrees to participate in a new APM that involves delivering care in new ways and new methods of payment is inherently incurring significant financial risk to do so. Consequently **CMS should designate *any* APM that is undergoing testing by the Innovation Center as an "Advanced" APM.**

3. Use Limited Scale Testing to Accelerate Innovation

Although most good alternative payment models will likely look like one of the models in the seven categories above, the parameters of the model – the payment amounts, the specific services included and excluded, and the accountability measures – will differ depending on the specific patients, conditions, services, and communities where the model will be used. For example, although oncologists and cardiologists could each use a form of condition-based payment to improve care for their patients and reduce spending for Medicare, the types of treatments that will be paid for and the outcomes to be achieved will differ significantly between patients with cancer and patients with heart failure, and so the payment amounts and performance measures in the APMs will also need to be different.

In most cases, however, providers face a "chicken and egg" conundrum in defining an Alternative Payment Model for specific types of conditions, procedures, and patients. Fully specifying the parameters of the APM requires information that can only be obtained from providers who are delivering services in a different way, but providers cannot deliver services in that way without having an alternative payment model to support them. For example:

- **Determining appropriate payment amounts for new or different services.** If an APM is going to support the delivery of a service that is not currently eligible for payment under current Medicare payment systems, the APM will need to specify how much will be paid for that service. However, it is difficult to estimate the cost of such a service if there is little or no experience in delivering the service due to lack of payment. For example, a payment model might be designed to pay a non-clinician educator to educate a chronic disease patient about how to avoid exacerbations, but it will not be clear how many patients can be adequately educated by a single individual, how much will need to be paid for an educator with the skills necessary to be effective, etc. until the APM is actually implemented.
- **Setting payment amounts for bundled services.** If an APM provides a bundled payment that replaces one or more current Medicare payments and also provides flexibility to deliver services that are not currently eligible for payment, the APM needs to specify how much will be paid for the bundle. However, it is difficult to estimate the appropriate payment amount without an understanding of how often current services would be replaced by new services, the extent to which fixed costs supporting existing services can be eliminated, etc. For example, many physicians would prefer an APM that replaces current Evaluation & Management payments (which are limited to face-to-face visits with a physician) with a monthly payment that would provide the flexibility to schedule patient phone calls with the physician instead of just office visits, to make contacts with patients using nurses instead of physicians, etc. However, it will not be clear how much these monthly payments should be until it is determined what proportion of office visits can be eliminated, what types of

additional staff of the practice, etc., and those changes cannot be made until the APM is actually implemented.

- **Defining methodologies for risk-adjusting/stratifying payments.** An APM that creates a bundled payment in place of fees for individual services will likely need to stratify or adjust the bundled payment amount to reflect differences in patient needs. However, the patient characteristics that affect the level of services may not be adequately captured by ICD-10 diagnosis codes. The APM would need to specify what combination of patient characteristics would be associated with each payment stratum and how much the payment amount would be, but it is difficult to do either of these things without data on how many patients have particular combinations of characteristics and how the appropriate services will differ for different characteristics. For example, an APM might create a monthly payment to support home-based palliative care services to patients, but the payment amounts would need to be higher for patients with lower functional status, less caregiver support, etc., and it will not be clear how many patients have those characteristics and how many patients in each category could be managed by a palliative care team until the APM is actually implemented.
- **Setting standards for performance on outcomes.** There is broad agreement that it would be desirable to have APMs that are designed to improve patient outcomes. However, there is little outcome data available that can be used for establishing baseline levels of outcomes and performance standards because of the significant costs involved in collecting outcome data and the lack of a business case for providers to incur those costs under current payment systems. For example, an APM might provide a flexible payment for managing knee or hip osteoarthritis that encourages use of alternatives to surgery; the APM would need to hold providers accountable for addressing pain and mobility problems in order to ensure they were not stinting on services, but data on expected levels of pain and mobility would not be available until they were collected through implementation of the APM.

Currently, CMMI will only test a payment model if it projects that the model will reduce Medicare spending. However, since it is impossible to confidently make such a projection without specifying the parameters of the model, CMMI's current approach means that most innovative models will never be tested.

To address this problem, **CMMI should create a process for "limited scale testing" of innovative alternative payment models**. The following five-step process should be used:

1. **Selection of Pilot Sites for Limited-Scale Testing.** When CMMI is presented with a proposal for a promising Alternative Payment Model (e.g., a proposal that has been recommended by the Physician-Focused Payment Model Technical Advisory Committee) where the information needed to fully specify the parameters or to estimate impacts cannot be obtained without implementing the APM on a limited scale, CMMI should issue a public call for physician practices or other provider organizations to volunteer to serve as pilot test sites. It should then select a small group of the volunteers who: (1) collectively serve a sufficiently large number of eligible Medicare beneficiaries to provide reasonably reliable data for setting the APM parameters; (2) are reasonably representative of the diversity of practice structures that would be eligible to participate in the APM if it were made widely available, (3) are located in different parts of the country that differ in terms of market structure, practice patterns, etc., and (4) are willing to collect the data necessary to set the APM parameters and to participate in a formative evaluation process.

2. **Implementation of APMs at the Pilot Sites.** CMMI and the pilot sites should agree on a set of initial "best guesses" for the APM parameters. The pilot sites would start delivering care as the APM intended, they would assess patients and assign them to payment categories using the initial definitions of those categories, and they would bill CMS for payments under the APM using the initial amounts. There would be an explicit understanding that the payment amounts would probably not be "right" initially, and so there would be a collaborative effort between CMMI and the pilot sites to assess the payment parameters frequently during the limited-scale testing process and to adjust the parameters as necessary in order to ensure that patients are receiving high-quality care and that the pilot sites are neither being financially harmed nor receiving financial windfalls at Medicare's expense. This would be consistent with CMMI's commitment to rapid cycle evaluation of payment models.
3. **Collection of Data for Refining Parameters.** The pilot sites should collect data on the time and resources involved in providing services to the patients, information on patient outcomes, etc. in order to refine the model parameters. Ideally, all or part of the cost of the data collection activities would be covered using funds or other assistance provided by CMMI.
4. **Decision About Broader-Scale Testing or Implementation of a Refined Model.** Following a period of limited scale testing, a decision would be made by CMS as to whether to pursue testing of a revised version of the APM with sufficiently broad participation to enable a summative evaluation of its impact on spending and quality. This decision would be based on the results of the formative evaluation as to the desirability of the APM for patients, for physician practices, and for CMS. In some cases, the benefits of the APM in terms of savings and quality improvement will be sufficiently large that it will be appropriate to immediately make the APM available to all interested providers and then monitor and refine it over time.
5. **Transition of Pilot Sites.** In order to encourage providers to serve as pilot sites, CMS should make a commitment to them that if a decision is made to terminate continued development and testing of the APM, a plan will be developed that would enable the pilot sites to transition out of the limited-scale testing process and return to standard payment systems without incurring any financial losses.

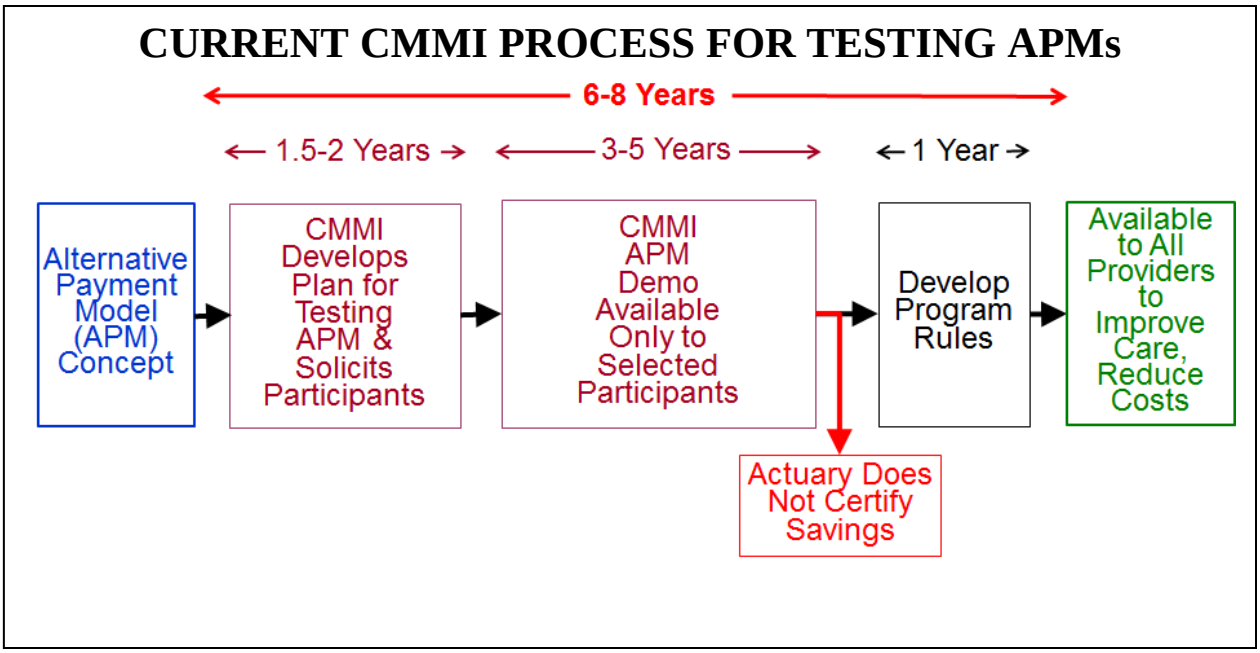
CMMI's authorizing statute clearly permits this type of limited-scale testing. There are no limits in the law as to (1) how many providers can participate in testing, (2) how the evaluation should be conducted, (3) how quickly a determination must be made as to whether the model improves quality or reduces spending, or (4) how often the design of a model can be modified before it is terminated or expanded. In fact, CMMI is prohibited from requiring that a model be designed to be budget neutral initially, and the law authorizes CMMI to modify the design and implementation of a model after testing has begun if the model is not expected to either improve quality without increasing spending or reduce spending without reducing quality.

Moreover, CMMI has already demonstrated the ability to simultaneously implement limited-scale testing for large numbers of care delivery improvement projects. Through two rounds of Health Care Innovation Awards (HCIA) in 2012 and 2014, the Innovation Center provided grant funds to support the implementation of 146 pilot projects testing innovative approaches to care delivery across a wide range of medical conditions. Many of the HCIA awards demonstrated that significant improvements in quality and reductions in spending were possible if healthcare

providers could receive the resources they needed to deliver care differently. However, none of the HCIA awards implemented a payment model that would enable continuation of the approach developed in the project beyond the award period and the expansion of the same approach to other sites. Moreover, while the HCIA grant funds could enable providers to pay for services that are not reimbursable under the fee-for-service system, the grants did not eliminate the financial penalties providers would face if they reduced reimbursable services. Therefore, it is essential for CMMI to expand the use of limited-scale testing to Alternative Payment Models.

4. Create a Faster, More Efficient Approach for Implementing APMs

When CMMI decides to pursue development and testing of an Alternative Payment Model, the process it uses is extremely long, complex, and resource-intensive. This not only slows down the process of testing and implementation but it reduces the number of models that CMMI can or will test. Although many proposals for innovative alternative payment models have been submitted to CMMI, most have not been implemented even after many months of discussion with CMMI staff and despite efforts to modify proposals to address concerns raised by CMMI. Once CMMI decides to pursue a payment demonstration, it typically takes 18-24 months or more from the time an initiative is first announced to the time when providers actually begin to receive different payments. Even if a payment model is succeeding and other providers would like to participate, the evaluation process will take 3-5 years to complete before a decision is made as to whether a payment model should be continued or expanded. As a result, under the current process for implementing APMs, it will take 6-8 years to make a desirable alternative payment model broadly available.



In addition, healthcare providers report that the process of applying to participate in CMMI payment models is very burdensome. Providers are expected to complete lengthy application forms requiring submission of data and other information that is expensive and time-consuming to assemble, and applications may be rejected for failure to meet non-substantive requirements such as maximum page limits. Applicants may be required to respond within a few days to

CMMI's requests for more information, but the applicants receive no commitment from CMMI as to when it will make a decision regarding their application. This uncertainty makes it difficult for a provider organization to know whether and when to start preparing for participation; starting preparation too soon could mean significant financial losses if the applicant is not accepted, whereas waiting until an application is approved to begin implementation planning could make it difficult for the provider organization to generate savings and quality improvements in the timeframes required in the demonstration.

Once accepted into a CMMI APM, providers are required to assemble and submit large amounts of data and to participate in a variety of meetings; these administrative activities can involve significant costs for providers and/or take significant amounts of their time away from patient care. There is generally little or no compensation provided to practices to offset these costs, even though CMMI spends tens of millions of dollars to pay the consultants who review the information the providers submit and organize the meetings they attend. Many providers, particularly small providers, have decided not to even apply to participate in otherwise desirable CMMI programs and others have dropped out of the programs in the early phases solely or partly because of the cost and time burden of participating.

Providers who do participate in CMMI payment models are told they can only count on the new payments lasting for a few years; the payments will only be continued beyond that if an evaluation proves that the program has saved money for the Medicare program. While this might sound like a very prudent approach, it can have the perverse effect of reducing the chances of significant success. Physicians, hospitals, and other healthcare providers are unlikely to fundamentally change the way they deliver care in response to a payment change that may only last a few years, and it is impossible to measure longer-term impacts on outcomes during an evaluation period that lasts only a few years.

CMMI has only been able to initiate testing of a few APMs each year because of the elaborate and expensive structure of monitoring and evaluation contractors and learning networks for providers that it creates for each APM. As of September, 2016, more than half of the funds spent from CMMI's appropriation had been used to pay for planning, research, evaluation, and technical assistance activities, rather than for payments to providers to improve the delivery of care.

If CMMI continues to use this same process for testing and implementing alternative payment models in the future, it would take a decade before the majority of physicians in the country would have the ability to participate in an APM designed for the types of patients they care for. This would also mean that relatively few Medicare beneficiaries could benefit from the higher quality care that would be possible under APMs and that the Medicare program would not achieve the significant savings that wider use of APMs could generate.

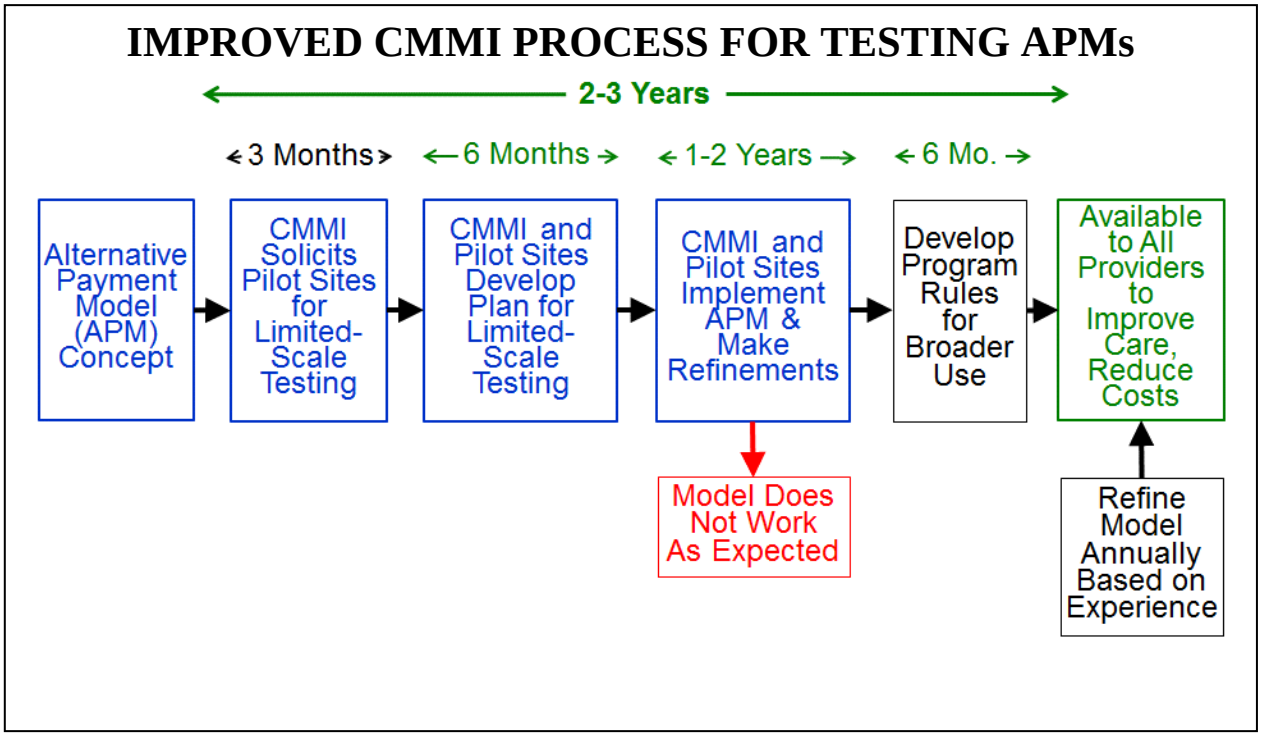
CMMI should completely redesign the processes it uses to test and implement alternative payment models in order to achieve the goals that are implicit in MACRA – every physician should have the opportunity to receive at least 25% of their revenues from well-designed alternative payment models in 2019, at least 50% of their revenues from APMs in 2021, and at least 75% of their revenues from APMs in 2023.

Just as many physicians, hospitals, and other healthcare providers are now re-engineering their care delivery processes to eliminate steps that do not add significant value, CMMI should use Lean design techniques and other approaches to identify and eliminate all steps and requirements in its implementation processes that do not add value or that impede achieving the goals that Congress has set. Moreover, reducing the number of consulting contracts on projects will free up CMMI staff time and funds so that more APMs can be implemented simultaneously.

As part of the redesign process, CMMI should also look for ways to reduce the administrative requirements it has imposed on providers participating in APMs. As noted earlier, the administrative burdens in many existing models discourages participation, particularly by small providers, and the burdens reduce the ability of providers to make the care improvements needed to achieve success under the APM.

To ensure that the MACRA goals are achieved, CMS should establish specific milestones that are designed to implement as many alternative payment models as possible and as quickly as possible. For example, the following timetable would allow alternative payment models to be made broadly available within 2-3 years after a proposed APM model is submitted to CMMI:

- When a desirable APM is proposed (e.g., when a physician-focused alternative payment model is recommended by the PTAC), CMMI should recruit and select initial pilot sites within 90 days.
- CMMI should then work collaboratively with the pilot sites to develop the initial parameters for implementing the APM. This process should not take more than six months.
- Over the next 12 to 24 months, the pilot sites would be paid through the APM and use the new payments to restructure the way they deliver care. CMMI and the pilot sites would work together to continuously refine the details of the APM to ensure it results in a "win-win-win" for the patients, the pilot sites, and the Medicare program.
- Assuming the results produced at the initial pilot sites confirm the desirability of the APM, CMMI would then develop the rules and procedures needed so that a larger number of providers could apply to participate in the APM. This would be completed within 6 months.
- Interested providers should then be permitted to apply to participate in the APM no less frequently than twice per year. Applications to participate should be reviewed and approved or rejected by CMMI within 60 days. Applications should only be rejected if an applicant cannot demonstrate that it has the ability to implement the APM, not because of arbitrary limits on the size of the program.



Once a provider begins to participate in an APM, they should be permitted to continue doing so as long as they wish to, unless CMS can demonstrate that Medicare spending under the payment model is higher than it would be under the standard physician fee schedule or that the quality of care for beneficiaries is being harmed. It is unlikely that providers will be willing to implement significant changes in care delivery if they believe the APM will only be available for a short period of time and that they will have to dismantle the changes they have made when the demonstration project ends. Section 1115A of the Social Security Act explicitly permits the Secretary of HHS to continue a payment model as long as the model is expected to improve the quality of care without increasing spending, reduce spending without reducing the quality of care, or improve the quality of care and reduce spending. Moreover, if a payment model is not achieving these goals, the law gives the Secretary of HHS the power to modify the payment model rather than terminate it. Decisions to continue or modify a model can be made before an evaluation of the model is completed.

In many cases, there may be no need for additional "testing" of a model before it is made broadly available to providers who wish to participate. If an APM is explicitly structured to assure CMS that Medicare spending would be lower than it would otherwise be, if sufficient data exist to set the parameters of the model, and if a large number of physicians, hospitals, and/or other providers want to participate in the APM, then it would be in the interests of beneficiaries and the Medicare program to allow as many providers to participate as are willing to do so.

Implementing new payment models without a formal evaluation is hardly unprecedented. All three of the principal payment systems that Medicare currently uses to pay physicians and hospitals were implemented without waiting for an evaluation of demonstration:

- The Inpatient Prospective Payment System (i.e., hospital DRGs) was designed and implemented for most hospitals across the country in 1983 without any evaluation demonstrating that it would work. It was implemented nationwide just 14 months after Congress passed the authorizing legislation.
- The RBRVS Physician Fee Schedule was implemented for all physicians beginning in 1992 after it was mandated by Congress in 1989, with no demonstration or evaluation of the payment system before it was implemented.
- The Outpatient Prospective Payment System was implemented in 2000 to pay hospitals for outpatient procedures, with no testing or evaluation prior to implementation.

Instead of being "tested" in an artificial demonstration, all of these payment systems were made available nationally in a phased but rapid approach. They were then monitored and regularly adjusted to correct any unanticipated problems and to adapt the payment systems as changes in science, technology, and other factors occurred over time.

Similarly, new Alternative Payment Models could be implemented and then monitored and regularly adjusted to correct any unanticipated problems and to adapt them as new technologies and research results appear. If at any point, CMS identifies a situation where quality is being harmed for a particular provider's patients, or where spending is not truly being reduced, that provider's participation in the payment model could be terminated, similar to what CMS can do today in its standard payment systems.

However, similar to the way Congress established the Medicare Shared Savings Program, physicians, hospitals, and providers should have the choice of whether to participate in APMs or to continue delivering services under the standard fee-for-service payment system. Not every physician or hospitals would need to participate in an Alternative Payment Model in order for the Medicare program to achieve significant savings, and it is likely that better results will be achieved by willing participants than by those who are forced to participate.

The Urgent Need for a New Approach to Innovation

When the Center for Medicare and Medicaid Innovation was created in 2010, the serious problems with the fee-for-service system were only beginning to be recognized and there was little agreement on what "value-based payment" should be. In that context, CMMI had to take the initial steps on its own to define and implement new payment models, and it is not surprising that it would proceed slowly to determine how best to do that.

In contrast, there is now widespread agreement that alternatives to fee-for-service payment are essential to improving the quality and controlling the costs of healthcare, and there is increasing recognition that current approaches to value-based payment have had disappointing results and the results are not likely to improve in the future. Even more significantly, a growing number of providers now see alternative payment models as an opportunity to deliver better care for their patients in a more financially sustainable way. Many physician practices, hospitals, medical specialty societies, and other stakeholders are actively working to develop Alternative Payment Models designed to support the specific kinds of care their patients need to achieve better outcomes at a lower cost. Finally, the increasingly serious problems that rapidly escalating healthcare costs are causing for patients, employers, and taxpayers has created an urgent need for

faster progress in implementing alternative payment models that will enable physicians, hospitals, and other healthcare providers to deliver better and more affordable care.

Congress gave the Center for Medicare and Medicaid Innovation both the statutory authority and the financial resources needed to rapidly develop and implement a wide range of truly innovative alternative payment models. It is time to radically redesign the processes used at CMMI so it can implement a larger and more diverse set of Alternative Payment Models far more quickly than it has in the past. This will enable CMMI to serve as the collaborative partner that is badly needed by the many physicians, hospitals, other healthcare providers, and other stakeholders who are developing innovate approaches to healthcare payment and delivery in order to create a better and more affordable healthcare system.

Thank you for the opportunity to comment. We would be happy to provide additional information on these recommendations and any assistance that you would find helpful in implementing them.

Sincerely,

Harold D. Miller
President and CEO