



September 29, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS–5519-P
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR) (CMS–5519–P)

Dear Acting Administrator Slavitt:

On behalf of the American College of Physicians (ACP), I would like to share our comments on the proposed rule on Advancing Care Coordination through Episode Payment Models (EPMs). The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 148,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

General Comments on Episode Payment Models

ACP appreciates that CMS is expanding its testing of additional bundled payment models through this rule. As we noted in our comments on the Medicare Access and CHIP Reauthorization Act (MACRA) proposed rule,¹ bundled payment and similar episodes of care payment models are best aligned with the type of services provided by internal medicine subspecialists. Many of our related subspecialty societies are looking at how bundled payment and episodic care models can be utilized as a platform for the development of specialty-specific Alternative Payment Models (APMs). To supplement these efforts, the College encourages CMS to immediately explore how models in this rule or in the Bundled Payment for Care Initiative (BPCI) can be expanded beyond the current inpatient-based tracks to be physician-focused

¹ https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf

rather than facility-focused. We are encouraged that CMS indicates its intention to test physician-led bundled payment and episodes of care models, and we recommend that CMS expedite this process to ensure that APMs are available for a broad set of subspecialists in the near future.

The College also reiterates its comments from the MACRA proposed rule regarding concerns with the level of “nominal risk” that must be met for a model to qualify for the Advanced APM pathway. The nominal risk requirement as proposed essentially requires a maximum risk of 4 percent of total health expenditures for the attributed population in an Advanced APM. This degree of risk-taking threatens the financial viability of most physician-led entities. Realistically, this level of risk is only suitable for larger, facility-based, integrated entities. The College recommends that the nominal risk requirement instead be modeled along the lines of the Medical Home Model standard, with risk being linked only to a percentage of Medicare Parts A and B revenue received by the entity, excluding any Part B drug costs. This risk requirement is more appropriate for physician-focused payment models with smaller, typically physician-led entities as the APM entity, which is in line with the structure of episodic payment models that may be best suited for many subspecialists. CMS also could include a requirement that the APM Entity lose the right to all or part of otherwise guaranteed payment or payments as one of the options if the APM entity's actual aggregate expenditures exceed expected aggregate expenditures.

Comments on Provisions of the Proposed Rule

Beneficiary Protections

ACP appreciates that CMS proposes to maintain the rights of Medicare beneficiaries to obtain healthcare services from their preferred physicians. The College strongly recommends that CMS work to ensure that patients, families/caregivers, and the relationship of patients and families/caregivers with their preferred physicians are at the forefront of the Agency’s thinking in the development of both the Merit-based Incentive Payment System (MIPS) and APM pathways. ACP also supports the proposal to prohibit hospitals from restricting beneficiaries to a list of preferred or recommended physicians based on participation in the EPM program. We further recommend that the Agency establish mechanisms to ensure that patient choice in physician preference remains protected throughout the course of the model.

Gainsharing and Other Savings-Related Payments

CMS proposes to apply record access and retention requirements to documents related to the calculation, distribution, receipt, or recoupment of gainsharing payments, alignment payments, distribution payments, and downstream distribution payments. ACP recommends that CMS strengthen this requirement by collecting information on gainsharing and other savings-related payments and the distribution of such payments by the facility to participating physicians and other healthcare professionals. In collecting this information rather than only requiring access and retention, the Agency can utilize these data for future efforts as well as to help examine the extent to which savings are equitably being shared by facilities with participating physicians and other healthcare professionals.

Acute Myocardial Infarction (AMI) Episodes

The Agency states that it selected the proposed EPM episodes based on their clinical homogeneity, site-of-service, and Medicare Severity-Diagnosis Related Group (MS-DRG) assignment considerations. ACP is concerned that, while patients with AMI may be perceived to be a homogeneous population, the clinical characteristics of these patients may vary significantly. ACP recommends that CMS work with the clinician community to limit ambiguity with regard to the clinical homogeneity of patients with AMI. With the move from ICD-9 to ICD-10 coding, the coding stages associated with AMI have changed, warranting additional considerations. The College recommends that CMS only include patients with a principal diagnosis of AMI in the EPM to ensure that the most clinically similar subset of patients is involved in the model. This approach would provide CMS the opportunity to clearly evaluate the impact of EPMs on patient care and outcomes for the most appropriate subset of the population.

Cardiac Rehabilitation

The College supports the proposed testing of an incentive payment to hospitals to be used to encourage increased coordination of cardiac rehabilitation services throughout the 90-day service period and/or beneficiary adherence to cardiac rehabilitation services recommended within their treatment plan. This support is based on the compelling evidence that the completion of a rehabilitation program can significantly reduce the risk of subsequent heart attacks and cardiac-related mortality. The College does not have the expertise to determine whether the proposed monetary payment is sufficient to achieve the stated goal, and encourages CMS to seriously consider comments from hospitals and the community of cardiology professionals to ensure the sufficiency of the incentive payment.

Advanced APM Implications

The College supports CMS' proposal to provide a pathway for Track 1 EPMs to be considered Advanced APMs and thereby allow participating physicians the ability to qualify for the additional bonus associated with Advanced APM participation. Providing additional APM options – especially for subspecialists who currently have no or few opportunities for APM participation – is important to ensure the broader movement toward more advanced, value-based models. However, the thresholds for payments for patients that must be met to be a qualifying participant (QP) in an Advanced APM are of significant concern, in particular beginning in 2023 when the thresholds are 75 and 50 percent, respectively. The episodic and bundled payment models being proposed or tested will cover a relatively small number of patients within a physician's patient panel, making it difficult if not impossible to reach the QP threshold for Advanced APMs. While we understand that the threshold amounts may be statutory and, therefore, outside of CMS' authority to modify, ACP strongly encourages the Agency to explore alternative means that would allow physicians who are participating in Advanced APMs to meet the QP thresholds.

Thank you for considering our comments. Please contact ACP's Walt Gorski, Director of Regulatory Affairs, by phone at (202) 261-4570 or e-mail at wgorski@acponline.org if you have questions or need additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert McLean MD". The signature is written in a cursive style with a horizontal line through the middle of the letters.

Robert McLean, MD, FACP, FACR
Chair, Medical Practice and Quality Committee
American College of Physicians