Advancing High Performance Health

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April 24, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Verma:

On behalf of the AMGA we appreciate the opportunity to comment on the Center for Medicare and Medicaid Services' (CMS') December 23, 2016 "Episode-Based Cost Measure Development for the Quality Payment Program" white paper. Founded in 1950, AMGA represents more than 440 multi-specialty medical groups and integrated delivery systems representing roughly 177,000 physicians who care for one-in-three Americans. Our member medical groups work diligently to provide innovative, high quality, patient-centered medical care that both improves patient outcomes and is spending efficient. For these reasons we have a significant interest in improving spending efficiency in order to lower Medicare spending growth.

At pages 17 through 20 the white paper poses a series of questions for public comment under five categories: Episode Group Selection; Episode Group Definition; Acute Inpatient Medical Condition Episode Groups; Chronic Condition Episode Groups; and, Cost Measure Development.

Episode Group Selection

AMGA supports CMS' use of prioritization criteria in forwarding this work. As CMS staff noted in their April 3 "update on cost measurement work" presentation at the American Medical Association (AMA), the 74 episode groups in Wave 1 represent seven of the eight clinical areas with the highest share of Medicare expenditures, include seven of the nine clinical areas with the most episodes, and include six of the 10 clinical areas with the largest number of unique Tax Identification Numbers – National Provider Identifiers (TIN-NPIs). All seven Wave One clinical areas have the potential for pairing with quality measures.

Acute Inpatient Medical Condition Episode Groups

CMS is interested in identifying "outpatient events that could be considered candidates for development as acute condition episode groups, which could include chronic condition exacerbations that require acute care but not inpatient hospitalization." CMS is interested in identifying "a single Acute Episode Group type that does not distinguish the place of service." We support this approach and recommend use of prioritization criteria in identifying these group types. It is well know chronic conditions that are highly prevalent and costly and do not necessarily require an inpatient hospitalization include arthritis, certain cancers, chronic obstructive pulmonary disease, cognitive impairment/dementia, congestive heart failure, diabetes, hypertension and kidney failure.

Chronic Condition Episode Groups

We recognize the inherent problem in identifying episode groups for chronic conditions. Nearly 50 percent of Medicare beneficiaries have three or more chronic conditions and 31 percent have one to two chronic conditions. Per the example given, we believe the latter option is preferable. That is, "develop a chronic condition episode specific to the manage of patients with diabetes, . . . , i.e., a patient condition group to better compare cost to treat like patients." Preferable still, "a single episode group for outpatient chronic care with adjustment for comorbidities and demographics of the population served by the clinician."

CMS makes no mention of functional status limitations. As Harriet L. Komisar and Judy Feder noted in their 2011 Georgetown paper, 15 percent of Medicare beneficiaries have any number of chronic conditions along with functional status limitations but account for 32 percent of Medicare spending. 1 Failing to account for functional status or functional limitations will cause CMS to substantially miscalculate episode group costs.

AMGA appreciates the difficulties associated with cost of caring for cancer patients or differentiating patients based on disease severity. For example, how would the agency account for a Medicare cancer patient that was diagnosed prior to turning 65 or prior to becoming Medicare eligible or account for metastasis or re-occurrence. We encourage CMS to examine the work being done in cancer registries that is, in part, related to bundling oncology services. For example, the work at Sutter Health led by Dr. Michael Van Duren.

Cost Measure Development

CMS seeks comments on the relationship between episode groups and, among other related issues, risk adjustment and quality. We have several comments.

Beyond problems associated with attributing delivered services by clinician and/or potentially weighing directly and indirectly attributed services by clinician or, as suggested, determining "percentages of the resources for an episode that could be attributed to physicians serving in different roles," we question whether any or all of these approaches will have a siloing effect or undermine care coordination.

Concerning risk adjustment, AMGA supports MedPAC's view that several elements including risk adjustment in Fee for Service (FFS), the Medicare Shared Savings Program (MSSP) or Accountable Care Organizations (ACOs) be "synchronized." Medicare should be managed as one program. Chapter two of MedPAC's June 2014 report discussed "improving risk adjustment in the Medicare program." 2 In

addition, we encourage CMS to factor in episode-based cost measures with the work the agency has done to date and continues to do related to risk adjusting for socio-economic and demographic factors.

Related to our comment above about cancer severity, AMGA supports the agency's interest in developing episode sub-groups that, as the agency notes, "further refines the specifications of episode trigger codes" "to yield more clinically homogenous cohorts of patients with similar expected cost."

CMS states the agency is "especially interested in comments regarding methods to align quality of care with cost measures and welcomes recommendations and suggestions." We are particularly pleased to see this issue raised. In several comment letters to CMS last year, AMGA raised the issue of achieving value, or calculating outcomes achieved relative to spending, for example, in our March 2016 letter in response to the proposed Quality Measurement Development Plan and in our June 2016 proposed MACRA rule comment letter. As we argued last year, if value is defined as outcomes achieved relative to expenditures, achieving quality without correlating quality performance to reductions in expenditures is, as Michael Porter has noted, self-defeating. 3 Consider the MSSP. None of the program's 34 quality measures address expenditures defined as the full cycle of care. This problem is not unique to the MSSP. HEDIS measures suffer the same shortcoming. We noted further it was not surprising that there appears to be no correlation between ACOs that earn shared savings and achieving comparatively superior quality performance. As currently conceived, MIPS quality and cost scores will be calculated independently. It does not appear CMS will correlate them. We believe this is a mistake. Over time the agency must establish a correlation between quality performance and expenditures or reduced spending – if for no other reason than if providers are required to invest a significant amount of time or expense in reporting measures, which as Lawrence Casalino and colleagues demonstrated in a March 2016 Health Affairs article, there should be a statistical correlation to financial performance. 4

CMS wishes to avoid any unintended costs in the development of episode-based cost measures. We share that concern. For example, CMS has an interest in avoiding disadvantaging clinicians caring for complex patients. This is particularly worrisome as CMS states for the purposes of improving care and accountability, the agency's goal is to make known episode costs attributed to individual physicians in real, or next to real, time. As CMS is well aware research and survey results show physicians, for example, cardiologists, will avoid accepting or treating complex or severely ill patients or upcode for complicating conditions to improve report card performance. There appears to be no easy or straight forward answers, however, via ever-improving sub-grouping and risk adjustment along with claims data analysis

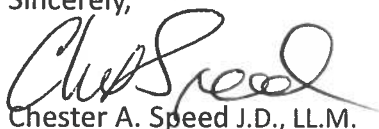
CMS is also interested in ways to incorporate Part D costs into episode group development. AMGA supports this intention. We suggest the agency begin by incorporating Part B drugs since the agency has the relevant claims data and these drugs, largely infusion drugs, tend to be comparatively the most expensive prescription medications.

Finally, AMGA believes developing episode-based cost measures presents CMS with several attendant benefits that the agency should work to exploit. Here are three. First, variation in health care spending in the US is well documented. Studies by the Congressional Budget Office (CBO), the Agency

for Healthcare Reseach and Quality (AHRQ), the National Center for Policy Analysis and the Dartmouth Health Atlas show per capital and per patient spending can vary by up to 100 percent. Over time MIPS eligible clinician (EC) cost scores should be used to inform related CMS programming to reduce, or reduce further, unwarranted practice variation. Second, CMS should apply to its episode-based cost measurement work evaluation findings resulting from the agency's bundled payment demonstrations. What can be learned from Lewin's ongoing evaluation of the Bundled Payments for Care Improvement (BPCI) demonstration. Third, thinking more broadly episode-based cost measures should be leveraged to inform more accurate Medicare Advantage (MA) financial benchmarking and quality star ratings.

We thank CMS for consideration of our comments. Should you have questions please do not hesitate to contact AMGA's David Introcaso, Ph.D., Senior Director of Public Policy at (703) 842.0774 or at dintrocaso@amga.org.

Sincerely,



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AMGA

<u>Endnotes</u>

1. Harriet L. Komisar and Judy Feder, "Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services," Georgetown University (October 2011), at: http://www.thescanfoundation.org/sites/default/files/Georgetown_Trnsfrming_Care.pdf.
2. MedPAC, Medicare and the Health Care Delivery System, Report to Congress (June 2014), at: http://www.medpac.gov/docs/default-source/reports/jun14_entirereport.pdf?sfvrsn=0.

3. Michael E. Porter, "Standardizing Patient Outcomes Measurement," <u>The New England Journal of Medicine</u> (February 11, 2016): 504-506. At: http://www.nejm.org/doi/full/10.1056/NEJMp1511701. See also, Michael E. Porter, "What Is Value In Health Care?" <u>The New England Journal of Medicine</u> (December 23, 2010): 2477-2481. At: http://www.nejm.org/doi/full/10.1056/NEJMp1011024.
4. Lawrence Casalino, et al., "US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures," <u>Health Affairs</u> (March 2016), at: http://content.healthaffairs.org/content/35/3/401.abstract.