Centers for Medicare and Medicaid Services (CMS): Innovation Center New Direction

In September, CMS released a request for information (RFI) seeking feedback on the new direction for the CMS Innovation Center. The Innovation Center seeks to promote patient-centered care and test reforms that empower beneficiaries, provide price transparency, increase choices and competition to increase quality, reduce costs, and improve outcomes. CMS identified six core guiding principles to help achieve these goals: Choice and competition in the market; Provider choice and incentives; Patient-centered care; Benefit design and price transparency; Transparent model design and evaluation; and Small-scale testing.

PAI’s Response

PAI agrees with the Innovation Center’s guiding principles, as these are the key elements that should be considered in the development of payment models. Additionally, PAI identified five overarching objectives for innovation to be used collectively with the core guiding principles to inform the future development and modification of APMs and Innovation Center models. These five objectives for innovation, are payment models should:

1. Provide increased flexibilities, incentives, and greater resources for physicians and other clinicians;
2. Be patient-centric and include elements that focus on patient needs, as well as encourage and incentivize patient engagement;
3. Include pilots and programs with clear guidance and enhanced clarity;
4. Rely upon input from, and collaboration with, state medical associations; and
5. Reduce the physician burden.

In response to the RFI, PAI provided comments based on the application of these principles and objectives, and more specifically on the different potential model categories outlined in the RFI, as well as responses to the specific questions posed in the RFI. A summary of PAI’s comments is provided below.

Increased participation in Advanced APMs for MACRA’s Quality Payment Program (QPP)

- Greater resources, including step-by-step guides, should be provided to physicians and other clinicians, which provide information and details on Advanced APM opportunities in their region and/or specialty, as well as how a physician would go about joining and participating in the different models, either directly or through an APM Entity.

- Similar flexibilities for small practices finalized as part of the CY 2018 QPP Final Rule should also be adapted for the Advanced APM pathway; providing an “on-ramp” for solo practitioners and small practices.
• **Other Payer Advanced APMs** – The requirement that clinicians submit their own payment or patient data for the All Payer Combination QP determination option may be a barrier to successful participation and for clinicians to become QPs. Payers and APM Entities, who have easier and timelier access to this data, and the ability to verify its accuracy, should be the ones who should bear the burden of data submission, but only after clinicians have been offered the opportunity to review their data prior to submission.

• **QP/PQ Thresholds** – The agency should consider decreasing the thresholds for QP/PQ determinations, including those for the All Payer Combination option, and to provide more resources and materials that help physicians and other clinicians better assess what their attribution would look like under an Advanced APM.

**Consumer-Directed Care & Market-Based Innovation Models**

• The agency should ensure that any price and quality data made available to patients is accurate and presented in a clear and concise way, that is easily understood, so as not to overwhelm patients. Transparency is essential, but it is also critical to ensure that the data and information being shared does not unintentionally misguide or misinform patients.

• Support patient incentives for selecting and aligning with “high-quality” physicians and other clinicians who are participating in an APM.

• A priority should be to incorporate elements that focus on the needs of different patient groups who may require translation services, including those who require language assistance or sign interpretation.

**Physician Specialty Models**

• Additional support is required to help develop and implement models that create more opportunities for specialists.

• Specialty (and other) APMs should be constructed to most efficiently integrate with existing and future APMs and other value-based payment arrangements, so that all clinicians have an opportunity to participate in an APM without conflict. The agency should ensure that clear guidance is issued on how the different models align and work-together/support each other, and where they differ.

**Medicare Advantage (MA) Innovation Models**

• Allow additional flexibilities when it comes to benefit designs, and MA innovation models, like the value-based insurance design demonstration and other future models, should encourage and provide physicians with greater flexibility to better manage the care for their patients.

• Allow physician contracts with MA plans that meet the risk, quality, and certified electronic health records technology (CEHRT) requirements to be included as Medicare Advanced APMs for the QPP.
State-Based and Local Innovation, including Medicaid-focused Models

- Develop state-based and local innovation models with input from, and in collaboration with, state medical associations, who can provide a valuable perspective and insight into the development of models based on their relationships with physicians and understanding of the current gaps of care in their localities.

- In situations where patients require services from multiple APMs, so their health care needs are better met, the agency should develop policies that ensure and support coordination of care for the patient's totality of care to ensure payment across Medicare and Medicaid programs as appropriate.

Program Integrity

Future model elements aimed towards program integrity should be developed with the following considerations:

- Empirical data from the program to support significant changes that could have a substantial impact on physicians' reimbursements.

- Clear guidance and specifications on the documentation required in the case of an audit under a specific model.

- Adequate time for physicians and other clinicians to respond to requests from the agency, with adequate notice of the issue and information being solicited in the response to an audit or other program integrity-related request.

- A symmetrical review and appeal process.

- Data posted publicly or supporting any program changes must be verified, accurate, and validated.

Do you have suggestions on the structure, approach, and design of potential models? Please also identify potential challenges or risks associated with any of these suggested models.

There are several issues that are related to a design element requiring the use of a specific technology that the agency should take into consideration, including:

- Many physicians and other clinicians in small practices may not have the financial resources to acquire a specific technology or related component.

- Physicians and other clinicians should not be penalized under model requirements for actions that are essential or the responsibility of the vendors providing or developing the technology.

- The agency to consider developing a “Vendor Compare” that would publicly report vendor capabilities, APMs their products can support, and vendor data and error rates, just as physicians and other clinicians participating in the payment models and the QPP are held accountable for their performance on Physician Compare.
Are there any other comments or suggestions related to the future direction of the Innovation Center?

- Remove barriers and ambiguity regarding model participation and opportunity to benefit from optimal payment. Extend, as appropriate, the application of the Federal Trade Commission (FTC) and Department of Justice (DOJ) Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations (ACOs) Participating in the Medicare Shared Savings Program (MSSP) to the entities under the potential models.

- Be mindful of other laws and regulations that could be impediments or obstacles participation in potential models, and that appropriate exemptions should be extended and applied, for example, Stark Law exemptions that are similar to those for group practices.