Specialists in Arthritis Care & Research

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November 20, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMMI New Direction
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Centers for Medicare & Medicaid Services: Innovation Center New Direction

Dear Administrator Verma:

The American College of Rheumatology (ACR), representing over 9,500 rheumatologists and health professionals, appreciates the opportunity to provide input on the *Centers for Medicare & Medicaid Services: Innovation Center New Direction* request for information. Rheumatologists provide highly specialized, ongoing, face-to-face and primarily non-procedure-based care for Medicare beneficiaries with acute and chronic conditions that can be difficult to diagnose, treat, and often cause disability and premature death. These conditions include rheumatoid arthritis, systemic lupus erythematosus, and vasculitis. Rheumatologic diseases including arthritis are the leading cause of disability in the country, and early and appropriate treatment by a rheumatologist is vital to controlling disease activity, preventing and slowing progression, improving patient outcomes, and reducing the need for costly downstream procedures and care. We welcome the opportunity to share our suggestions as CMMI moves toward an innovative payment system embracing quality and value.

Guiding principles and focus areas

The ACR is pleased that the Centers for Medicare and Medicaid Services (CMS) is engaging with stakeholders on the new direction of the Centers for Medicare and Medicaid Innovation (CMMI). We believe the guiding principles and focus areas of CMMI align with our priorities. We strongly support Provider Choice and Incentives, Patient-centered care, Benefit design and price transparency. We are pleased to see a focus on increased participation in advanced alternative payment models (APMs), specifically physician-focused specialty models and prescription drug models. We also encourage CMMI to pursue state level initiatives; we believe working at the state level with relevant stakeholders on payment innovation is extremely important.

Model designs consistent with CMMI guiding principles

The ACR agrees that a well-crafted physician-focused APM must be flexible to be viable and attractive to the diverse range of providers who provide care in a wide variety of practice settings across the country. Toward that end, the ACR is currently developing a Rheumatoid Arthritis (RA)-specific APM with adaptability in multiple dimensions. Not only is it designed to guide future reimbursement from CMS, but also it will serve as a template for payment reform and new contract negotiations with third-party commercial payers. Importantly, the RA template can also be easily adapted or expanded for use with other diseases. We believe this approach, based on flexibility in multiple domains, is innovative and will enhance uptake of value-based reforms.

Structure, approach, and design of potential models

We feel there are several pragmatic barriers to participation in an APM by subspecialists such as rheumatologists. Many of these barriers are related to the fact that rheumatologists' practices are small. This increases the burden of financial risk and reduces opportunities for economy of scale. In order to move significant numbers of physicians into APMs, the financial risk and patient thresholds must be reduced. We strongly suggest to CMS a proposal to lower the threshold for requirements to make "qualifying participant" in an advanced APMs more achievable for smaller practices. We propose CMS lower the patient count threshold from 20% to 10%, lower the payment threshold from 25% to 15% and consider delaying or softening the planned year-over- to year increases in these thresholds. We believe the current thresholds are too stringent for small practices and specialty practices. This has been identified as a major impediment to APM participation, in our efforts to develop a condition specific APM for rheumatologists. We look forward to working with CMS on ways to mitigate risk and encourage providers to participate in the APM track.

The ACR's APM addresses the treatment of RA, a life-long condition whose appropriate care varies depending on the stage of the disease. The APM reflects the varied involvement of the rheumatologist during these distinct stages, splitting payment into an initial stage for diagnosis (including, for example, communication with primary care physicians), followed by ongoing care stratified by disease severity and recognizing other illnesses that complicate treatment. This model aligns payment with physician work and reimburses for services that have traditionally been undervalued. Quality measures are built into the APM to ensure that treatment adheres to best practices. We believe the services provided by cognitive specialists such as rheumatologists are undervalued in the current system, and the additional training and expertise of rheumatologists are not recognized. Additionally, non-face-to-face care and chronic disease care coordination reimbursement as currently configured is inadequate for the time and effort required to comply with current codes In the ACR's RA-APM, these valuable services which may prevent costly or unnecessary procedures are appropriately reimbursed while simultaneously designed to lower overall costs.

Potential challenges or risks associated with suggested models

The ACR appreciates the opportunity provided by the agency's decision to encourage the development of physician-focused APMs, and we hope that CMS will make it less burdensome for physician-focused APMs to achieve "advanced" status by reducing nominal risk. As above, the current nominal risk criterion makes it untenable for smaller practices to attempt the APM track. Smaller groups engaged in physician-focused APMs cannot be expected to assume or be able to manage the same degree of financial risk as large organizations such as ACOs. We continue to urge CMS to allow the set-up cost of physician-focused APMs to serve as the financial risk, at least on an interim basis.

Options beyond FFS and MA for paying for care delivery

For a number of reasons, the ACR strongly supports parity between Medicare and Medicaid payments. This will improve patient access and help compensate for the increased administrative burden associated with providing care for Medicaid beneficiaries – including difficulties with formularies, imaging, and referrals in network. We applaud CMS's decision in the Quality Payment Program (QPP) year 2 final rule to allow physician participation in Medicare Advantage (MA) APMs to count toward the threshold for advanced APM participation. We believe the addition of MA patients to non-MA patient databases will help reduce the skewing of performance measures, which have been observed by rheumatologists to vary by patient insurance. Further, by combining all patients in one group the data will be more comprehensive and reliable.

Further engagement of beneficiaries in development of models

The ACR believes that stakeholder engagement is of utmost importance during the development and testing of any model. We encourage transparency throughout the process and strongly suggest any new payment models go through the full public rule making process.

Additionally, we suggest that CMS host roundtables with patients and providers who would be impacted by any proposed models. We believe public engagement with CMS can help facilitate the development of attractive models with greater and more rapid uptake. We hope that CMS will gain more understanding of regional differences by engaging at the state, regional and local levels. We suggest CMS consider a listening tour or even shadow physicians to better understand the day-to-day realities of specialty and sub-specialty practice. The ACR would be happy to assist in coordinating such outreach. We further invite CMS to meet and discuss with the ACR Executive Committee or Board of Directors how any proposed models might affect rheumatology practices.

Furthermore, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) has expressed the desire to provide technical assistance to the organizations developing APMs. Currently PTAC does not have the authority to work with an organization until a proposal has been submitted. We recommend that PTAC have the option to work with interested groups before submission to enhance feedback, speed

development, and increase the likelihood of success. We would further suggest CMS put in place processes for CMMI to engage with groups developing and submitting APMs.

Future direction of the Innovation Center

We urge CMMI to consider Congress's role in making health policy changes, improving the sharing of data from CMMI testing, and strengthen beneficiary safeguards. Strengthening safeguards should ensure that all models are small-scale, voluntary tests. We believe models should be tested in a limited population to minimize unintended consequences. We feel that greater transparency, improved data sharing, and a broader collaboration with relevant stakeholders will help to ensure that demonstrations are widely embraced and supported, in contrast to recent episodes that saw widespread resistance from patients and the healthcare community.

Further, we believe innovative payment models, specifically physician focused APMs are a way of also reducing administrative burden on providers. Time and energy can be saved if administrative burdens for filling out paper work such a prior authorizations or reducing the amount of "clicks" needed to enter information for MIPS is reduced. We believe the more rheumatologists that are able to participate in APMs, the more time they can spend with their patients managing their complex care needs.

The ACR is dedicated to ensuring that rheumatologists and rheumatology health professionals have the resources they need to work with CMS and provide patients with high-value care. We believe that for CMS, clinicians, and patients to achieve their objectives, payment programs must be aligned with high-value patient care. The ACR appreciates the work that CMS does and the opportunity to respond to this CMMI request for information. We look forward to being a resource to you and to working with the agency.

Please contact Kayla L. Amodeo, Ph.D., Director of Regulatory Affairs, at kamodeo@rheumatology.org or (202) 210-1797 if you have questions or if we can be of assistance.

Sincerely,

David I. Daikh, MD, PhD
President, American College of Rheumatology