JAYNE KOSKINAS TED GIOVANIS | Foundation For Health and Policy

November 1, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1677-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Comments on the Manner in which CMMI operates

Dear Ms. Verma:

The Jayne Koskinas Ted Giovanis Foundation for Health and Policy (JKTGF) appreciates the opportunity to provide comments on the manner in which the Centers for Medicare and Medicaid Innovation (CMMI) develops and manages experimental payments models. Our comments come from decades of developing and managing experimental and other payment systems.

Background

One of the most important goals at CMS is fostering an affordable, accessible healthcare system that puts patients first. The CMMI was created to foster this objective. Because there have been questions about the payment and care delivery models the CMMI has developed and the mandatory nature of some such models, the Centers for Medicare and

Medicaid Services (CMS) is soliciting ideas through an informal Request for Information (RFI). Accordingly, the CMS/CMMI is seeking public feedback on a new direction to promote patient-centered care and to test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes. The CMMI desires input on ideas on additional ideas and concepts, and the future direction of the CMMI.

Our comments are addressed across four distinct dimensions which follow.

Preclusion of Administrative and Judicial Review

As the Patient Protection and Affordable Care Act (PPACA) was being developed the CMS had included provisions that preclude any administrative or judicial review of several of the PPACA provisions. The agency has for decades attempted to insulate itself from challenge through various means and the PPACA provided such an opportunity. Unfortunately, the PPACA included a provision precluding from review anything that the CMMI seeks to undertake.

In the development of any experimental payment model or arrangement there needs to be mutual trust between CMMI and the organization engaging in the payment model, and a focus on the common goal of achieving a positive result or learning from the model. There needs to be a fluidity of processes – it is experimental. Thus, there is an existent mutuality among the regulator or payer and the providers (those implementing the models). This process must recognize that the experiment may evolve and may not go as planned and that changes will be needed to assure successful execution. Thus the inclusion of the preclusion requirement for CMMI experiments creates an inherent imbalance where one side is totally in charge, which destroys any mutuality that might otherwise exist.

Because it is in the statute, we do not believe that the preclusion requirements can be waived by the agency. Therefore, the only logical remedy is for the agency is to request Congress to repeal at least the CMMI preclusion provisions. This will unshackle the agency, allow trust by providers and result in the freer development of experimental projects, which was the very reasoning for including the CMMI in the PPACA.

Quality measurement

The current system of quality measurement is very complicated and not easily understood by patients. There are too many measures, and some of those measures are based on arcane, and probably inappropriate statistical models. At the same time, the existent quality measures may not be adequate and certainly do not adequately reflect outcomes. There are currently some 1500 quality measures, many are no longer useful. To that end the National Quality Forum is undertaking a review of the quality measures, hopefully for the purpose of defining better measures.

There has been an effort to provide patients with composite score type measures or indicators of provider quality. Having 25-30 or even more quality measures is complicated enough but then attempting to combine them into a meaningfully composite measure using weights that are arbitrary will not yield a meaningful indicator of quality for policy measurement nor for patients. Having said that, composite measures can be useful but there needs to be a rigorous discussion of the appropriate weighting methodology to use before such methodology is selected as the weighting methodology can have an enormous effect on the resultant provider ranking.

The definition and selection of quality measures should be revisited and should begin with the establishment of some basic principles, with a particular focus on outcome measures that are relevant to patients. Thereafter, the measures may be selected. The next questions are - when are composite measures useful, and how should they be constructed?

The risk adjustment methods that have been used for some of the quality measures, and for the construction of composite measures are often far too complex, apparently making use of opaque statistical techniques for their own sake, rather than because they are particularly applicable to the situation. There has been discussion in the literature regarding the problems with some of these methods. In addition, the risk adjustment has not taken sufficient account of the impact of socio-economic status on the quality measures. This has also been the topic of much discussion in the literature.

The quality measures should focus on whether the goals of the patient were achieved. Examples of these goals could be: restoring mobility, curing an infection, relief of pain, or even achieving a more comfortable death. There should be an assessment of whether the care has resulted in the

desired/expected result, rather than some fixed outcome. Resuscitation and live discharge of a suffering and dying patient with a DNR order may improve a hospital's mortality score, but may not be a desirable result from the viewpoint of the patient.

Encouragement of innovative payment models

Developing and testing innovative payment and care delivery models is critical for the betterment of the healthcare system. . The focus should be to identify payment models that are innovative and that show promise of identifying something that could be scaled to broader application. It is likely that several models will evolve as it is unlikely that any single model would be applicable to all geographies in the country. To this end the CMMI should seek to evolve many experimental payment models in the hope of identifying a few that can be scaled or, at a minimum, find other ideas that could then be developed into pilot projects.

CMMI must evolve these payment models with a sense of experimentation. Such will be developed based on a mutual trust and understanding that the models will evolve over time. Trust needs to exist on both the providers and the CMMI. This cannot be accomplished if CMMI has the final say on evaluations and calculations, and does not have to consider comments from the participants, which is the case given the existence of the preclusion of review provisions discussed previously. In the current experiments or bundled pay models those that desire to participate generally will have analyzed the included care modalities and have ascertained that their base is sufficiently robust that it mitigates their risk. If successful, what do these prove? Organizations with a low base or that are already efficient are unlikely to participate, particularly if they are unable to appeal errors in any CMMI evaluations, or calculations of rewards/penalties.

Population based approaches to payments

If properly defined these approaches can provide good, comprehensive incentives for efficient provision of care. However, one issue with the existing system is that the risk bearer does not have the patients assigned to it for a very long period. We believe that, on average, the insured's are only with any particular plan for 3.8 years. Thus, the insurer may not have an enduring incentive to provide health care that is focused on long term savings at the population level. Accordingly, it is important to define the

population covered, and to adjust for patient dumping or selection. This has not always been done.

The attribution of patients has sometimes been done arbitrarily and retrospectively based on patients that have been served by the provider in the preceding period. The best way is to attribute patients to care or risk managing entities up front and to define the bundle of services for which they are responsible along with a definition of the measurement criteria for success. This way the care practioners will know who they are serving and across what bundle of service and how success will be measured.

We appreciate the opportunity to provide these comments. If you have any questions regarding these comments, we would welcome the opportunity to engage in a discussion of the substantive points above.

Sincerely,

/s/

Theodore Giovanis