RISK EVOLUTION TASK FORCE

AMERICA'S PHYSICIAN GROUPS

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RETF In-Person Meeting

CMMI Panel

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Summary

Task force members broke up into six groups to discuss salient successes and challenges in current CMMI models and provide feedback directly to CMMI staff who oversee these programs.

Topics:

- The tension physician groups face between wanting to see current models evolve and improve, and the challenge that comes with participating in constantly changing programs;
- CMMI should consider lengthening the review time before changes are implemented (including application windows) and provide additional technical support
- Critical benchmarking flaws:
    - new payment opportunities (telehealth, CCM/TCM codes); CMS should consider having a period where groups can test new concepts and payment codes without having them count against the benchmark
    - Using Historical costs when provider is below county or national benchmark
- The positive impact and importance of waivers (Stark, SNF 3-day, telehealth), but CMS should consider allowing broader access to these by allowing groups in upside-only arrangements have access to them
- Flexibility around beneficiary incentives by lowering copays for high-value care, telehealth, and finding ways to disincentive low-value care
- The difficultly groups still face with attribution including the categorization of NPs and finding a better way to distinguish between specialty care and primary care
- Challenges with rules surround the annual wellness visit – forced bill for multiple visits to provide additional services and removing patient barriers including copays. Don't require 12 months between annual wellness visits
- Model overlap. It's critical that CMMI consider how all these models interact and coexist with each other.
- CMMI/ CMS needs to fix the HCC cap
- Challenges to smaller groups
    - Interested in paying claims but no mechanism to assist
    - Physician governed groups show best results, but these groups don't have access to capital in the same way as venture capital backed or big systems; it would be fantastic to

have a path that would be able to assist in smaller groups to have less financial burden, access to payments to fund programs at ACO level
    - To meet APM threshold for MIPS, continues to increase over time. May be Impossible to meet with current models
- Challenges in ACO programs
    - Highly efficient groups disincentivized to remain in the program due to diminishing margins and historical benchmarking; how is CMS going to sustain the model and recognize that some ACOs out there are already performing and won't get incrementally better
    - No mechanism to reflect costs to administer and stand up ACO in shared savings
    - Needs to be a mechanism to protect early adopters
- Require health plans to report MA data is same format that CMS uses for FFS so groups can more easily use analyze populations across different metrics
- MA works because of narrow networks. Can the ACO program integrate narrow networks as well?
- TIN vs. TIN/NPI distinction. CMMI needs to allow additional flexibility here
- Access to the "black box" of data that CMS uses to determine benchmarking

Action Items

CMMI staff requested follow up from groups in attendance. APG would like your help gathering the following information:

- If CMMI were to allow increased flexibility around cost sharing, what would groups be interested in seeing? Create a wish list.
- What is a good level of ROI on a capitated contract? Give numbers.
- What sorts of social determinant of health would you be interested in capturing or quantifying? Clinically relevant subgroups: Frail elderly as an example … could there be a risk adjustment based off of PACE?