June 20, 2016

To: Health Care Plan Learning and Action Network (HCPLAN)

From: AMGA

Re: HCPLAN "Coronary Artery Disease" White Paper: Comments

On behalf of AMGA we appreciate the opportunity to comment on the HCPLAN's "Coronary Artery Disease" white paper. AMGA, founded in 1950, represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Our member medical groups are interested in all forms of episode-based or bundled payment arrangements. AMGA members have a strong desire to improve the quality and effectiveness care delivery, or in achieving the triple aim of improving the experience of care, improving the health of populations, and reducing spending or the per capita costs of health care.

AMGA has five comments in response to the draft.

1. Measuring for Value

This paper, like the LAN's "Performance Measurement" white paper, mentions value numerous time. For example, the paper states on page one, "Both public and private purchasers are exploring how best to promote acceleration and alignment of these models because episode payments offer a particularly promising approach to efficiently create and sustain delivery systems that advance value, quality, cost effectiveness, and patient engagement." Yet, again, as in the "Performance Measurement" white paper, there is no discussion of value or measuring outcomes over spending. AMGA argued at some length in its May 23rd response to the "Performance Measurement" draft, performance improvement cannot be attained absent measuring for value.

2. Unique Devise Identifier (UDI)

The white paper discusses percutaneous coronary interventions (PCIs) that frequently use stents or scaffolds. The white paper also makes mention of patient safety under "10. Quality Metrics." Specifically, the paper makes note of the Society of Thoracic Surgeons' registry to improve safety and outcomes of care. Therefore, as AMGA did it its March 28th comment letter in response to the LAN's "Elective Joint Replacement" draft white paper, we note again the importance of employing the FDA's Unique Device Identification (UDI) system. It is disappointing this paper as well does not make mention of the UDI system particularly because, as AMGA stated in our March 28th letter, in the CMS ACE demonstration providers used cheaper surgical implants, equipment and materials in both the orthopedic and cardiovascular DRGs to produce the greatest cost savings.

3. Reconciling Financial Overlap

Under "7. Payment Flow," the paper somewhat vaguely makes mention of this issue or problem but makes no recommendation. The paper states, "If the payment flow is retrospective reconciliation of FFS payments and the accountable entities are both expecting to share in gains or losses, one critical issue will be the manner in which those gains or losses are split within the time period of the procedure episodes." We also addressed this issue or made a recommendation in our "Elective Joint Replacement" comment letter. We stated,

> Profit sharing should include non-episode providers in cases where the patient is receiving simultaneous or ongoing care. Profit sharing should also include the patient to incent self-activation. Profit sharing also avoids the perception or reality that in a world where providers are caring for the whole person and addressing population health needs, bundled payment arrangements fragment or silo care, are redundant and competitive. Bundled payment arrangements should create synergy between and among providers.

4. Risk Adjustment

The draft only makes mention of risk adjustment. Under "9. Type and Level of Risk," the draft states, "Risk adjusting the episode price, based on the patient severity within the CAD population, is one risk-mitigation strategy." This is not just "one risk adjustment strategy" but a critical aspect in the goal of, under "Type and Level of Risk," encouraging "broad provider participation."

5. Regional Versus National Pricing

Under "8. Episode Price," the paper recognizes the variation in spending by region. On page 19 the paper states,"On the other hand, if the region, on average, has a higher per bundle cost than other regions (or specific providers within the region), the payer may not achieve as great a level of savings than if the episode price was to be set at a national or provider-specific level." Variation in spending suggests the problem of unwarranted variation that can be significant even within the same region. For example, per the Dartmouth Atlas, the rates of coronary stenting is three times higher in Elyria than in Cleveland, two cities thirty miles apart. If the intent of episode-based or bundled payments is to lower spending growth at least in part by reducing unwarranted variation, a national spending factor needs to be incorporated in setting episode prices. For example CMS's Next Generation ACO demonstration employs a national efficiency percent discount that compares risk adjusted regional fee for service spending to a risk adjusted national fee for service per capita spending.

Thank you for offering AMGA an opportunity to comment. We look forward to continuing to work with the HCPLAN to evolve further episode-based payment arrangements. If you have any questions please do not hesitate to contact David Introcaso, Ph.D., Senior Director for Regulatory and Public Policy, at dintrocaso@amga.org.

Thank you.

Donald W. Fisher
President and CEO