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May 25, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS Request for Information on Direct Provider Contracting Models

Dear Administrator Verma:

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS's or the Agency's) Request for Information on Direct Provider Contracting Models. The Association of American Medical Colleges is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 151 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The AAMC supports alternative payment model (APM) programs that seek to promote high-quality, efficient care while retaining at their core the essential patient-physician relationship. Chief among these efforts are accountable care organizations (ACOs) and bundled payments initiatives. Academic medical centers (AMCs) have been leaders in testing new payment models, including Medicare Shared Savings Program (MSSP) ACO, Next Generation, CPC +, and other models. AAMC is also a facilitator-convenor for the Bundled Payments for Care Improvement (BPCI) initiative for 21 hospitals and 14 health systems. In addition, AAMC provides support for providers implementing the Comprehensive Care for Joint Replacement (CJR) program and Oncology Care Model (OCM). The lessons garnered from this experience heavily inform the content of the AAMC's comments.

Through alternative payment models, there is the potential to lower cost, promote care coordination and improve quality of care. AAMC shares CMMI's commitment to the transition from fee-for-service to value-based care and believes the Innovation Center's leadership will continue to accelerate this transition.

GENERAL COMMENTS ON THE DIRECT PROVIDER CONTRACTING MODEL

According to CMS' description of the model in the RFI, CMS could contract directly with participating practices, such as primary care practices and larger multi-specialty groups to establish the practice as the main source of care for services ranging from solely primary care to a wide range of professional services for beneficiaries that voluntarily elect to enroll with the practice. CMS could pay the practices a fixed per beneficiary per month payment (PBPM) to cover the services that the practices would be expected to furnish under the model. In addition, the practices could have the opportunity to earn performance-based incentives for the total cost of care and quality.

As homes of large multi-specialty group practices and a wide range of both facility-based and community-based primary care practices, academic medical centers are interested in learning more about this direct provider contracting model and providing feedback on issues to consider if it were implemented. By way of background, faculty physicians in academic medical centers frequently are organized as multispecialty faculty practice groups under a single tax identification number (TIN) and treat the most vulnerable patients, those individuals who are poor, sick, and have complex medical needs. Data from the Faculty Practice Solutions Center (FPSC), a joint product of Vizient and the AAMC, is helpful for an understanding of the breadth, depth and complexity of these large faculty practice groups. Recent FPSC data on 87 practice plans shows that they range in size from a low of 128 individual NPIs to a high of 4,319, with a mean of 989 and a median of 816. These practices groups include over 70 adult and pediatric specialties; this does not include numerous additional subspecialties, such as burn surgery, and cardiac surgery, to name a few.

As CMS explores this direct provider contracting model, the AAMC encourages CMMI to consider the following overarching recommendations that reflect the perspective of these large multi-specialty practices.

Maximize Flexibility

As CMS considers this new model, it is important to provide maximum flexibility to providers interested in participating. CMS should support additional opportunities for practice transformation for organizations that are prepared to take on additional risk and offer opportunities for new entrants that make participation more attractive. There should be a gradual transition to downside risk in models and a cap on downside risk for "catastrophic cases." Providers need time to detect utilization trends and identify opportunities for interventions without being concerned with downside risk.

Minimize Burden

This model should take care to minimize reporting burdens on physicians and physician groups.

Ensure Success of Existing Models

CMS and providers have invested considerable time and resources in existing models under the CMMI program, such as episode based models (e.g., BPCI, CJR), Accountable Care Organization (ACO) models (e.g., Pioneer, Next Generation, the Medicare Shared Savings Program), CPC +, and others. It is important that CMS continue to allocate resources to the

models that are showing long term promise in addition to any new models, such as the direct provider contracting model under consideration. Recent results have shown that providers participating in the Medicare Shared Savings Program (SSP) for a longer period of time are more likely to achieve greater savings. There needs to be an opportunity to realize the returns of the investment put into these models and to adapt the existing programs to make them successful.

Incorporate Direct Provider Contracting into Existing Models

We encourage CMS to consider providing a capitated payment model option (such as the direct provider contracting model) in existing models, such as ACO models. A capitated payment model, paired with pay-for-performance elements, and an engaged patient population could be successful in achieving better quality care and lowering cost.

Address Model Overlap

One of the challenges faced by CMS and providers is managing the overlap of beneficiaries, providers, and savings in these different models. If the overlap is not addressed appropriately, participants in these models will be confused and providers may decide not to participate. As CMS considers this new direct provider contracting model, it will be important to set forth clear, concise guidance on how the overlap will be managed.

CMS should ensure that models are aligned so that providers are not discouraged from participating in models. For example, there are concerns about the overlap of bundled and episode based programs with ACOs, particularly related to conflicts when patients attributed to an ACO are also evaluated under a bundled payment program. Under current CMS policy, a bundled payment participant maintains financial responsibility for the bundled payment episode of care and any gains or losses during that episode are linked to the bundled payment participant and removed from ACO results following the close of the performance year. CMS should more closely evaluate the effects of this overlap as these models move forward and create policies that encourage participation.

Include Appropriate Risk Adjustment in the Model

The direct provider contracting model must be designed so that providers are held accountable for factors within their control, typically through the use of appropriate risk adjustment or clinical exclusions. Monthly payments to DPC-participating practices and quality measures used in the model must be risk adjusted to account for socioeconomic factors and clinical complexity. Physicians in academic medical centers tend to disproportionately treat disadvantaged and vulnerable patient populations, and therefore could be unfairly penalized by programs that do not have adequate risk adjustments.

Expand Opportunities to Participate in Advanced Alternative Payment Models

The AAMC encourages CMS to continue to allow more opportunities for physicians to be qualified APM participants and receive the 5% incentive payments as participants in advanced alternative payment models under the Quality Payment Program (QPP). As CMS develops a direct provider contracting payment model, we encourage CMS to recognize this model as an Advanced APM. Identifying models as advanced APM models will encourage physicians to participate in the models.

Support Investment in Primary Care

AAMC strongly supports increasing investment in primary care and urges CMS to recognize the importance of team based care. Many important tasks are involved in managing a patient's care outside of the traditional E/M visit; however, most of these services are not reimbursed.

Physicians need flexibility to manage the health of their patient populations and provide additional services, such as care management and consultation with physician specialists that are not covered in the traditional payment system. Payments should be designed to include the cost of providing these care management and care coordination services and to enable physician practices to redesign care. While the ultimate goal is to achieve "better health, better care, and lower costs," it is also important to ensure that physicians providing that care are not overwhelmed and "burnt out" from administrative and regulatory burdens. It is critical to ensure that there is a primary care workforce. Supporting the next generation of physicians so that they thrive in medicine is essential to ensuring that our country has the supply of physicians that we need.

This direct contracting model could increase the interest of medical school graduates in residency programs in undersupplied fields, such as primary care and psychiatry, by incorporating payment for care management, consultation, telehealth and other services that have significant limits on Medicare reimbursement, reducing administrative burden, and providing more flexibility to manage their patient's health.

RESPONSE TO RFI QUESTIONS

The RFI poses a series of questions regarding the direct provider contracting model. The AAMC's responses to selected questions follows.

Provider Participation

Q) How can a Direct Provider Contracting (DPC) model be designed to attract a wide variety of practices, including small, independent practices, and/or physicians? Specifically, is it feasible or desirable for practices to be able to participate independently or, instead, through a convening organization such as an ACO, physician network, or other arrangement?

To attract a wide variety of practices, CMS should design a model that gives maximum flexibility to practices, especially related to taking on additional risk. There should be a gradual transition to downside risk in models to give providers time to detect utilization trends and identify opportunities for interventions without being concerned with downside risk. There should also be a stop loss so that risk is capped, particularly if there are "catastrophic cases." While CMS should allow flexibility for different types of arrangements, it would most likely be more desirable for practices to be able to participate through a convening organization, such as an ACO or other third party conveyor. Having a larger organization would enable the practices to better manage their populations and to spread risk to a larger number of participating beneficiaries, in addition to potentially having greater capacity to manage the administration of a PBPM.

Q) What features should CMS require practices to demonstrate in order for practices to be able to participate in a DPC model (e.g., use of certified EHR technology, certain organizational structure requirements, certain safeguards to ensure beneficiaries receive high quality and necessary care, minimum percent of revenue in similar arrangements, experience with patient enrollment, staffing and staff competencies, level of risk assumption, repayment/reserve requirements)?

Some of the features that CMS should consider include:

- A sufficient number of primary care professionals and other types of physicians to care for the defined population. Access to other health professionals (eg. pharmacist, nutritionist).
- A minimum number of participating beneficiaries.
- The ability to provide care for high risk and complex patients.
- Experience in quality performance programs.
- Sufficient funds available to invest in the model.
- The use of certified electronic health records.
- A history of, or demonstrated commitment to population health management.
- Demonstrated ability to provide a minimum access to care for PCP and specialty physicians.
- Limits to risk.

Q) What types of data (e.g., claims data for items and services furnished by non-DPC practice providers and suppliers, financial feedback reports for DPC practices) would physicians and/or practices need and with what frequency, and to support which specific activities?

Practices would need information on patient demographics, beneficiary-level claims data and prescription drug use for all services provided to a beneficiary during baseline and performance periods. This will enable providers to see what has happened to their patients, regardless of whether or not the care was provided within their practice. This data is critical for providers to identify targeted care interventions and redesign care. We recommend that CMS provide this data to practices regardless of whether they participate in APMs as it will enable them to improve care.

Under a direct provider contracting model, DPC practices will need access to information related to behavioral health and substance abuse in addition to physical health care. Primary care practices have become the prevailing location for patients to receive treatment that addresses all their health needs, behavioral as well as medical. One of the significant barriers to integrating behavioral and physical health care that currently exists is the removal of the behavioral health information from the records that are shared with the practices due to confidentiality rules under SAMHSA. For physicians and other health care professionals to provide effective care, they must have access to all of their patients' treatment history and current medications. Robust sharing of patient information is necessary for coordinated clinical treatment, improving the quality of care and maintaining population health.

Beneficiary Participation

Q) Medicare FFS beneficiaries have freedom of choice of any Medicare provider or supplier. Given this, should there be limits under a DPC model on when a beneficiary can enroll or disenroll with a practice for purposes of the model (while still having freedom of choice while enrolled in the DPC practice) or how frequently beneficiaries can change practices.

For purposes of the model, CMS should facilitate ways for practices to better engage beneficiaries. Examples of mechanisms to engage beneficiaries include incentives (e.g. gift cards, free transportation). As with traditional Medicare, beneficiaries should have freedom of choice to receive services from any Medicare provider or supplier. However, CMS could incentivize beneficiaries to access care as directed by their chosen primary care physician by setting lower out of pocket costs for the in network providers. DPC practices should be able to communicate the benefits to the patient of receiving the services at their practice rather than elsewhere to ensure the patients are highly engaged with their DPC practice while still having freedom of choice.

Q) The Medicare program, specifically Medicare Part B, has certain beneficiary cost-sharing requirements, including Part B premiums, a Part B deductible, and 20 percent coinsurance for most Part B services once the deductible is met. CMS understands that existing DPC arrangements outside the Medicare FFS program may include parameters such as no coinsurance or deductible for getting services from the DPC-participating practice or a fixed fee paid to the practice for primary care services.

To encourage beneficiaries to seek services from the DPC practices, CMS could eliminate the deductible and copayments for those services.

Payment

Q) Which currently covered Medicare services, supplies, tests or procedures should be included in the PBPM payment? Should items furnished by other providers and supplier practices be included?

If this is a primary care focused direct provider contracting (DPC) model, CMS could cover the primary care services the practices would be expected to furnish under the model, which could include office visits, certain office-based procedures and other non-visit based services. CMS should include coverage for telehealth, care management, inter-provider consultation and coordination, and behavioral health services. Many activities which are not covered under the traditional Medicare benefit can improve health outcomes and reduce the need for expensive services.

Services that support efficient, timely access to the appropriate clinical expertise should be prioritized and recognized in the PBPM payment. This includes clinician-to-clinician electronic consultation services, such as eConsult and SCAN-ECHO programs. An eConsult is an asynchronous consultation, whereby primary care providers seek clinical advice from a specialist colleague, documented in the electronic medical record. Typically, eConsults allow patients to avoid the cost and inconvenience of an in-person specialty visit, and maintain more of their care

in the primary care medical home, albeit with the benefit of specialty input as requested by the PCP. SCAN-ECHO provides video-based, case review and guidance from a specialist to a trained PCP. Both services are highly patient-centered and have received high marks from PCPs and specialists alike.

If the DPC model includes services beyond primary care, the practice should demonstrate that it has adequate coverage. For example, if patients with Hepatitis C are treated by the practice and part of the DPC model, then the specific CPT codes and services related to treatment of Hepatitis C would be included in the PBPM payment.

Q) Should monthly payments to DPC-participating practices be risk adjusted and/or geographically adjusted, and, if so, how? What adjustments, such as risk adjustment approaches for patient characteristics, should be considered for calculating the PBPM payment?

Monthly payments to DPC-participating practices must be risk adjusted and geographically adjusted to reflect costs of providing care and to avoid unintended consequences. Risk adjustment should account for socioeconomic factors in addition to clinical complexity. Physicians in academic medical centers tend to disproportionately treat disadvantaged and vulnerable patient populations, and therefore could be unfairly penalized by programs that do not have adequate adjustments for clinical complexity and socioeconomic factors.

Over the past several years, a substantial amount of literature has recognized the impact of sociodemographic status (SDS) factors on cost and patient outcomes.^{1,2} Recent reports released by the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine (NAM) on accounting for social risk factors in the Medicare performance programs have provided evidence-based confirmation that accounting for patients' sociodemographic and other social risk factors is critical in validly assessing the quality of providers and cost of providing care. The reports demonstrate that providers caring for large numbers of disadvantaged patients are more likely to receive penalties in the performance programs. Both reports clearly show that there are implementable mechanisms by which SDS data elements can be incorporated into these programs.

As a starting point, CMS should review the risk adjustment methodology and the geographic adjustments used in existing programs, like the ACO program, to determine the financial benchmarks. Another first step would be to examine the risk adjustments used in the Medicare Advantage program to inform the risk adjustment approach.

In some programs, including Medicare Advantage, CMS uses CMS-Hierarchical Condition Categories (CMS-HCC) risk adjustment model. Analysis has shown the CMS-HCC risk adjustment model under-predicts the actual medical expenses of the highest-cost beneficiaries, while over-predicting the actual medical expenses of the lowest-cost beneficiaries. Therefore,

¹ Michael Barnett, MD, et al. *Patient Characteristics and Differences in Hospital Readmission Rates*. *JAMA*, 2015. Retrieved from: <http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2434813>

² Jianhui Hu, et al. *Socioeconomic status and readmissions: evidence from an urban teaching hospital*. *Health Affairs*, 2014. Retrieved from: <http://content.healthaffairs.org/content/33/5/778.full>

using only HCCs for risk adjustment raises concerns and may discourage practices with complex and vulnerable beneficiaries from participating in this model.³ CMS should examine potential modifications to the CMS-HCC risk adjustment model to develop a method for more accurate predictions of medical expenses for the highest and lowest cost Medicare beneficiaries. In addition to the HCC, other measures that could be included are functional assessments, cognitive assessments, and SDS adjustment (starting with dual eligibility).

Q) What financial safeguards or protections could CMS offer where DPC-enrolled beneficiaries use greater than anticipated intensity or volume of services?

CMS should incorporate caps on total losses to mitigate financial risk and enable providers to experiment in care redesign efforts. Any losses should be limited to a percentage of the amount of the Part B professional services revenue from the practice.

Q) Should practices be at risk financially (upside and downside risk) for all or a portion of the total cost of care for Medicare beneficiaries enrolled in their practice, including for services beyond those covered under the monthly PBPM payment? If so, what should be included and how should risk be determined?

Practices should **not** be at risk financially for the total cost of care for Medicare beneficiaries enrolled in their practice. It would be too much risk for a physician practice to be held accountable for costs, such as inpatient and outpatient hospital care, post-acute care, drugs, and other costs beyond physicians' control. Instead, total risk should be based on a percent of the Part B professional revenues for the practice rather than total cost of care. CMS could design a model that holds physicians accountable for some metrics related to cost of care and for practices that do not meet those metrics, they could be held responsible for repaying performance based payments under the model. This would be a first step, and if the practice was able to manage ambulatory care, subsequent programs could expand the care included as the practice gains experience.

Q) How should quality be measured? Should it be similar to ACOs and other initiatives? What types of measures?

For primary care focused direct provider contracting models, we recommend CMS adopt a common set of cross-cutting measures. For the Medicare program, we recommend using the ACO/shared savings model measures. This will enable physicians to focus and drive change in specific targeted areas. In addition, many practices have past experience reporting the ACO measures.

If CMS has a non-primary care focused DPC model, CMS would need to use a set of measures that are specific to the disease or condition related outcomes. For example, if CMS has a non-primary care focused DPC model that uses Hepatitis C bundles, quality should be determined based on measures specific to that condition or disease.

³ <https://bipartisanpolicy.org/wp-content/uploads/2017/02/BPC-Health-High-Need-High-Cost-Medicare-Patients.pdf>.

Safeguards

Q) *How can CMS ensure that DPC participating practices do not engage in activities to attract primarily health beneficiaries (“cherry picking”) or discourage enrollment of complex patients?*

“Cherry picking” primarily healthy beneficiaries or discouraging enrollment of complex patients is a significant concern with the DPC model and CMS should set forth safeguards to prevent these types of activities. One approach to reducing incentives to select healthy beneficiaries would be to ensure that there is appropriate risk adjustment for clinically complex patients and patients with sociodemographic factors. CMS could make higher payments to practices that treat a high proportion of complex or vulnerable populations enrolled in DPC model or make a separate add on payment to these practices.

CMS can also establish regulations that restrict marketing practices that would be designed to target primarily healthy beneficiaries. There is precedent in the Medicare Advantage program for requirements related to marketing of plans that safeguards against activities geared toward enrolling primarily healthy beneficiaries.

In addition, CMS should examine some of the prior demonstrations and programs that had issues with “cherry picking” and reflect on steps that were taken those programs to address these problems. CMS can also implement program integrity efforts aimed at preventing such activities.

ACOs

Q) *For those in ACOs, how can CMS attract more physician practices to accept 2-sided risk? What additional waivers would be necessary?*

Attracting more physician practices to accept 2-sided risk will depend on potential financial opportunities being adequate to support the investments needed to improve quality and coordinate care. Physicians will need to engage in new and expanded activities to meet quality goals and to manage care. The cost of redesigning care delivery to improve outcomes is significant. There are also costs associated with ongoing data analysis, proactively scheduling patients, electronic health record changes, communicating with patients on follow-up care, organizing multi-disciplinary teams, and adding new staff and in particular adding new program management. CMS needs to account for these costs when determining reimbursement to physician practices in order to make two-sided models more attractive. CMS could make upfront payments to practices to assist in these investments that are needed to make the program successful. CMS should also consider a “catastrophic stop loss” formula to avoid downside risk from unexpected conditions and other circumstances that arise.

Design features that would make 2-sided risk models more attractive to physicians include the following:

Allowing Higher Upside than Downside Risk

Models that allow for a higher upside than downside risk, such as the ACO Track 1 plus model, would also be more desirable to physicians. With increasing calls to take on risk, it is important to recognize that ACOs remain in Track 1 in large part due to the high levels of risk required in the two-sided models. Two sided models (MSSP Track 3, Next Generation) include risk levels that are significantly higher than what the vast majority of ACOs can bear. Minimum Savings Rate (MSR) and Minimum Loss Rate (MLR) are also key components of an ACO model design that represent the percentages by which an ACO's actual expenditures differ from their benchmark, after which point the ACO would be eligible to earn shared savings or would be required to repay losses. Allowing ACOs to have a choice of symmetrical MSR/MLR; no MSR/MLR; or 0.5% increments between 0.5% and 2.0% would make the ACO more attractive. After surpassing the ACO's MSR, there should be first dollar savings. In addition, setting limits on losses would increase the willingness to accept some risk.

Retrospective or Prospective Beneficiary Assignment

We recommend that ACOs be given the option of prospective assignment (similar to ACO Shared Savings Track 3) or preliminary prospective assignment with retrospective reconciliation. Smaller ACOs may favor a retrospective assignment model where the ACO can add beneficiaries throughout the year. However, other ACOs would prefer a prospective model, which enables them to avoid volatile benchmark changes and employ data analysis and beneficiary engagement techniques from the start of the performance period on a population for whom they know they are responsible.

Adjusting from Year to Year to Account for Changes in Beneficiary Health Status

CMS' method for making risk adjustments for beneficiary health status in current models is flawed because it does not account for patient conditions that worsen over time for continuously assigned beneficiaries. We recommend that CMS allow risk scores for ACOs to increase year over year within an agreement period to account for conditions of continuously assigned beneficiaries that may worsen.

Compliance and Payment Waivers

Waivers of applicable fraud and abuse laws, such as Physician Self- Referral ("Stark") and Antikickback, are also needed to encourage participation in two sided risk models. This includes waivers that would enable flexibility in distributions of shared savings among physicians and waivers to allow some medically related beneficiary incentives to encourage preventive care and compliance with treatment. Such waivers are critical to remove legal and regulatory barriers that restrict providers from working together to provide better coordinated care.

Other Waivers

CMS can also increase participation in 2 sided models by making available to ACOs waivers of the following:

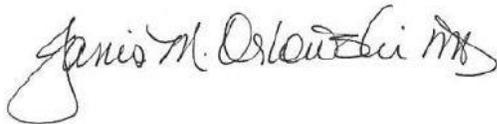
- **Skilled Nursing Facility (SNF) Three Day Stay** rule, which requires a 3 day prior hospital stay in order for inpatient SNF care to be covered
- **Telehealth requirement** for payment that limit the geographic setting and provider setting in which the telehealth services may be received.
- **Homebound requirements** that mandate a beneficiary be confined to the home to receive coverage for home health services
- **Medicare primary care coinsurance** that would reduce or eliminate cost-sharing for primary care services.

Waiving these requirements will enable ACOs to more effectively coordinate care, improve quality and reduce costs.

CONCLUSION

Thank you for the opportunity to present our views. We would welcome the opportunity to work with CMS on designing the direct contracting payment model or other topics that involve the academic medical center community. If you have any questions, please contact Gayle Lee at 202-741-6429 or galee@aamc.org

Sincerely,



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