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May 25, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Request for Information: Centers for Medicare & Medicaid Services, Direct Provider Contracting Models

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) on direct provider contracting (DPC).

Our members support the health care system moving toward the provision of more accountable, coordinated care and are redesigning delivery systems to increase value and better serve patients. **As such, the AHA supports the development of models that improve beneficiaries' access to care and providers' ability to provide high-quality care that best meets their patients' needs.** In particular, the AHA appreciates that CMS is thinking about ways to reduce clinical and administrative burden for providers by offering them access to beneficiary engagement tools, and considering innovative changes to claims submission processes.

As described in the RFI, CMS proposes to create one or more DPC models and begin testing the models through Medicare contracts with primary care practices. Through these contracts, CMS would pay participating practices a fixed per beneficiary per month (PBPM) payment to cover beneficiaries' primary care services (including, for example, office visits, certain office-based procedures, and other non-visit-based procedures covered under the Physician Fee Schedule). CMS would grant participating practices flexibility in how they deliver otherwise billable services and would offer them the opportunity to earn performance-based incentives for lowering the cost and improving the quality of care. The proposed model will feature voluntary enrollment for beneficiaries and the ability to take on two-sided risk for providers.



The proposed DPC models raise important questions about the parameters and implementation of such a model. However, the lack of detail included in the RFI makes it difficult for providers to conduct well-informed analyses in response to the questions CMS posed. **Accordingly, we urge CMS to develop the model as transparently as possible so that potential participants can make fully informed decisions about participation. More specifically, we recommend CMS consider our stakeholder feedback and continue to release additional information about its plans for a potential DPC model.**

PROVIDER/STATE PARTICIPATION

In its RFI, CMS solicits input on how it should design a DPC model to attract a variety of practices and what support physicians and their practices would need. To successfully participate in a DPC model – or in any alternative payment model (APM) – participants need timely access to their data, readily available in a readable format. When providers are held responsible for the total cost of care, or even a portion of it, they must be able to understand their patient population in a detailed way so as to recognize areas where changes in care could improve patient outcomes and reduce system costs. Similarly, to work toward earning performance-based incentives, providers need data to be able to identify areas of improvement for their practices. **To that end, we urge CMS to explore and dedicate resources to determine methods that would provide participants with complete, timely – ideally real-time – and understandable data.** By doing so, CMS would empower providers to maximize the effectiveness of any care redesign efforts they undertake as part of their participation in a DPC model. Additionally, we urge CMS to release the full 100 percent file Standard Analytic File for physician/carrier and durable medical equipment so that hospitals can better manage the total cost of care.

We also urge CMS to recognize the care redesign efforts and other initial upfront investments that providers make when joining a new model. These investments represent real financial risk for providers, who undertake significant changes in their care delivery and administrative practices in order to participate in new models.

Because providers also need accurate and reasonable benchmarks to make participation in a DPC model feasible, **we urge CMS to improve upon its existing benchmarking methodologies to help ensure that participants do not have to compete against their own best performance.** Participants that generate savings and achieve quality incentives should not be penalized in subsequent performance years by having their success make future savings more difficult to achieve. Instead, CMS could, for example, adopt a benchmarking methodology that accounts for the true amount of savings participants in a DPC model achieve as compared to providers not participating in the model. **We urge CMS to seek comment on any options for benchmarking methodologies that it considers incorporating into a DPC model.**

We also urge CMS to provide maximum flexibility to providers in how they would enroll and participate in a DPC model. **We urge CMS to allow participants to enroll either as individual physicians by National Provider Identifier (NPI) number or as a group using the group's Tax Identification Number (TIN).** Furthermore, we urge CMS to empower participants to identify and place beneficiaries in the clinical setting that best serves their short- and long-term

recovery goals. **To do so, CMS should waive the physician self-referral law and the Anti-kickback Statute with respect to financial arrangements formed by participants in a DPC model that comply with the model's requirements, as it currently does for accountable care organizations (ACOs), to enable participants to form the financial arrangements necessary to succeed.**

Additionally, the waiver of certain Medicare program regulations is essential to enabling physician practices to coordinate care and ensure that it is provided in the right place at the right time. **We, therefore, encourage CMS to waive certain payment rules and to offer to DPC participants the Skilled Nursing Facility (SNF) "3-Day Rule" Waiver that it provides to ACOs.** Waiving payment regulations such as certain hospital discharge planning requirements, telehealth requirements, the inpatient rehabilitation facility (IRF) "60% Rule," the IRF "Three-hour Rule," and the home health homebound rule is essential, as these regulations frequently inhibit care coordination. These waivers also would provide participants with valuable tools to increase quality and reduce unnecessary costs, commensurate with the level of risk and accountability that CMS is asking them to assume through DPC and other models as it shifts the burden of risk further away from the Medicare program onto providers. **Because waivers of the fraud and abuse laws and payment rules mentioned here would be essential to participants' success in a DPC model, we urge CMS to announce the waivers it will offer as part of any such model before the model's application due date.**

BENEFICIARY PARTICIPATION

CMS also solicits feedback on the supports providers need to enroll their patients in a DPC model. CMS's RFI indicates that any DPC model will place beneficiaries in a central role in their care by empowering them to select a primary care practice and by providing beneficiary engagement tools to practitioners to empower beneficiaries, their families, and their caregivers to take ownership of the beneficiary's health. **The AHA is pleased to see CMS offering beneficiary engagement tools to providers and encourages the agency to specify the precise tools it will offer to providers. These tools are important mechanisms for aligning provider and beneficiary incentives, a necessary step in improving the cost and quality of care.**

However, while empowering beneficiaries to take responsibility for their health is an important element of the move from volume- to value-based care, providers in a DPC model need a substantial period of time to impact the cost and quality of care for patients and need reliable information on their patient population to redesign care and meet performance-based incentives. If beneficiaries are able to switch their primary care practice at will without consequence, it will be impossible for providers to achieve this. **Therefore, we urge CMS to incorporate into DPC models periods during which beneficiaries may not disenroll from the practices they have selected.** Such enrollment limits will allow providers longitudinal access to patients, which is essential for making a meaningful impact on patient outcomes in the primary care setting, and will enable providers to make investments in patient care based upon a reasonable estimate of the PBPM payments they expect to receive. **To further support physicians in their efforts to reduce cost and improve the quality of care, we urge CMS to ensure beneficiaries will be prospectively attributed to providers in any DPC model.**

PAYMENT

CMS's RFI contains several questions seeking input on the payment structure and risk-sharing arrangements that should be incorporated into the DPC model. The balance of risk and reward incorporated into any DPC model must create adequate opportunities for all providers to move onto and along the risk continuum, including for those that are still working toward taking on significant risk. **To that end, we urge CMS to offer graduated levels of risk in any DPC model that it pilots (while ensuring the risk is sufficient for the DPC model to qualify as an advanced APM).** Creating opportunities for providers to participate in the advanced APM track of the Quality Payment Program (QPP) established by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 should be a central consideration of any model development. **We encourage CMS to announce the levels of risk required for participation in a DPC model before providers must apply for participation.**

Similarly, we urge CMS to ensure the PBPM payment in any DPC model is sufficiently high to attract a range of providers whose patients may have a variety of medical conditions. Accordingly, the PBPM payment must be adequately risk adjusted to reflect any such conditions. A robust risk adjustment methodology is essential to ensuring that a DPC model does not inappropriately penalize participants treating the sickest, most complicated and most vulnerable patients. **We urge CMS to publish clear and precise details about the risk-adjustment methodology it selects as soon as possible, as the methodology will be a key consideration for providers who consider applying for participation.**

Importantly, we also strongly urge CMS to not cap risk score growth. There are many plausible scenarios under which providers could see significant fluctuation in the risk profile of their patients and artificially suppressing risk scores so that they do not account for these fluctuations would penalize providers who care for a particularly sick population in a given year. Additionally, depending on any enrollment and disenrollment limits CMS includes in a DPC model, year-to-year turnover of beneficiaries aligned to DPC providers could result in highly varied patient profiles from one year to the next. These unknowable factors require careful consideration of risk adjustment practices and the selection of a sufficiently flexible risk adjustment methodology. **We also urge CMS to carve supplies such as immunizations and ancillary services out of the PBPM patient, as primary care physicians have little control over the cost of these items and services.**

GENERAL MODEL DESIGN

In addition to specific questions, CMS seeks feedback on general model design, including how the agency can limit the burden of the model on providers and better measure quality performance. **The AHA is pleased that CMS is committed to reducing burdensome requirements for DPC participants and other participants in new models. This will help allow America's hospitals and health systems to better provide high-quality, efficient patient care.** The AHA recently [reported](#) on the regulatory burden faced by providers and appreciates CMS's efforts to minimize regulatory burden to the greatest extent possible. This

commitment is in line with the Administration's "Meaningful Measures" initiative, a streamlined approach to quality measurement that can help ensure programs are focused on the core issues that are most critical to providing high-quality care and improving patient outcomes.

In order to gather necessary data while limiting burden, **we urge CMS to ensure the quality measures it incorporates into the model are targeted to the primary care that would be delivered through the model.** For example, CMS could consider a measure that captures whether beneficiaries are receiving high-priority, age-appropriate screenings in a timely fashion, such as a Patient Health Questionnaire measure to evaluate whether patients receive a screening for depression on a yearly basis.

CMS also should ensure that the reporting required for quality measures included in a DPC model can be easily extracted out of existing medical records and synergizes with other measures on which primary care providers are already collecting information. We also urge CMS to conduct a more thorough analysis of the proposed model's impact on quality and access so as to consider quality measures that capture data that cannot be reflected in traditional pay-for-performance measures. We encourage CMS to publish the results of any such analysis and of any other efforts it undertakes in the selection of quality measures and offer stakeholders an opportunity to comment on the measures.

PROGRAM INTEGRITY AND BENEFICIARY PROTECTIONS

CMS states in its RFI that a DPC model in which providers are accountable for the total cost of care could carry various risks for patients and requests input from stakeholders as to how it should protect beneficiaries from these risks. To address these concerns, **we urge CMS to ensure it incorporates adequate safeguards against stinting on needed care and cherry picking only the healthiest patients so that any DPC model improves care and access for all beneficiaries who enroll in the model.** A transparent, robust risk-adjustment methodology would be one such safeguard.

To further protect patients' access to care in a DPC model, **we urge CMS to prohibit participating providers from balance billing patients for the difference between what Medicare will pay under the DPC model for patients' care and what providers choose to charge.** Medicare's current rules limiting balance billing provide important financial protection for consumers who already spend a significant percentage of their incomes on premiums and other medical expenses. Moreover, if providers can charge patients in addition to receiving payment from Medicare through a DPC model, patients would face considerable uncertainty about the cost of services, which may cause some to forgo necessary care and others to incur unexpected out-of-pocket costs. **Also, we urge CMS to consider access issues when deciding whether to allow participating providers to charge patients "concierge fees" in exchange for enhanced services and/or deductible and co-insurance fees beyond what can be charged under Medicare.** All of these possible arrangements could limit access for low-income beneficiaries, and we encourage CMS to keep this in mind when further developing the DPC model.

EXISTING ACO INITIATIVES

In its final two questions, CMS requests input as to how it could strengthen existing ACO initiatives to attract more participants and address specific needs of physicians, including what additional waivers would be necessary to enable more practices to participate in existing ACOs. The AHA and its members appreciate CMS's consideration of waivers and other provisions that are necessary for enabling a greater proportion of practices to accept two-sided financial risk. As discussed above, **we urge CMS to adjust existing ACO initiatives by incorporating a fairer balance of risk and reward that encourages providers to take on additional risk but does not penalize those who need additional time and experience before doing so.**

As CMS considers refining existing ACOs and developing any future models, including DPC models, **we urge CMS to evaluate all APMs in a holistic fashion so that the agency creates aligned incentives across the delivery system, including consistent approaches to measuring cost and quality performance.** CMS should avoid the uncoordinated proliferation of a large number of models, which could lead to a "pile on" effect that makes it far more challenging for providers to focus and execute to the best of their ability. **In doing so, CMS should consider whether providers will be able to simultaneously participate in a DPC model and other primary care APMs, so as to ensure that any new models are not disruptive to the care redesign efforts and improvements that providers already are making in conjunction with their participation in other APMs.**

Finally, we strongly encourage CMS to publish additional, detailed information about a DPC demonstration before calling for model applications. As described herein, there remain a number of unanswered questions about the proposed models, making it difficult for hospitals and health systems to make an informed decision about applying to participate in the model. We also encourage CMS to seek public comment on the models it begins to describe in this RFI and on any modifications it makes to existing APMs that arise out of this RFI.

Again, we thank you for your focus on improving value for patients and providers and for your consideration of our comments. If you have any questions, please feel free to contact me or have a member of your team contact Shira Hollander, senior associate director of payment policy, at (202) 626-2329 or shollander@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President
Government Relations and Public Policy