AGS Geriatrics Healthcare Professionals

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May 25, 2018

SUBMITTED ELECTRONICALLY VIA
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Adam Boehler
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation
ATTN: CMMI RFI on Direct Provider Contracting Models
2810 Lord Baltimore Boulevard
Baltimore, MD 21244-2613

Re: CMMI RFI on Direct Provider Contracting Models

Dear Mr. Boehler:

The American Geriatrics Society ("AGS") greatly appreciates the opportunity to comment on the Center for Medicare and Medicaid's Innovation's (CMMI) RFI on Direct Provider Contracting Models. The AGS is a not-for-profit organization comprised of over 5,000 physician and non-physician practitioners who are devoted to improving the health, independence, and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our mission is to advance efforts that promote high quality of care, quality improvement, and increased payment accuracy for providers (physicians and other professionals) paid under Medicare.

Our comments below are based on the understanding that the intent of the DPC model(s) is to allow for the creation of something similar to the Comprehensive Primary Care Plus (CPC+) Model modified to allow for a larger number of participants, especially small practice participants. While other options may also be allowed, we believe this to be one of the best and our comments have that focus. We appreciate CMS proposing to expand the CPC+ concept because currently, participation in CPC+ is limited to certain geographical regions (14) and not all practices that hoped to participate were selected. Below you will find answers to the specific questions outlined in the RFI.

Questions Related to Provider/State Participation

1. How can a 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?

We believe that practices should have the choice of participating independently or through a convening organization because each practices decision to participate will be based on practice specific factors such as experience with APMs, size, location, ability to understand and address risk, etc.

2. 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)? Should these features or requirements vary for those practices that are already part of similar arrangements with other payers versus those that are new to such arrangements? If so, please provide specific examples of features or requirements CMS should include in a DPC model and, if applicable, for which practice types.

We support minimum requirements for practices but ask that CMS take care not to add further administrative burdens that may negatively impact patient care. The requirements outlined for the CPT care management services (CPT codes 99490 and 99487) may be a good starting point. CMS should not duplicate the requirements for CPC+ because, if it does, then AGS believes it would be better just to expand CPC + and not create a DPC model that is identical to CPC +. That said, to the extent that practices will be bearing financial risk, they should be required to have experience with bearing such risk and/or CMS should ask practices to disclose their experience and should preferentially choose practices with experience. Total cost of care risk bearing would also require minimum beneficiary enrollment, whereas responsibility for care tied to monthly payments that cover primary care services only can be accepted by a practice of any size.

The practice requirements for the CPT chronic care management codes are as follows:

The care management office/practice must have the following capabilities:

- *Provide 24/7 access to physicians or other qualified health professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week;*
- *Provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;*
- *Provide timely access and management for follow-up after an emergency department visit or facility discharge;*
- *Utilize an electronic health record system so that care providers have timely access to clinical information;*
- *Use a standardized methodology to identify patients who require care management services;*

- *Have an internal care management process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner;*
- *Use a form and format in the medical record that is standardized within the practice;*
- *Be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.*

While practices interested in participating in the DPC model should not need to be part of a large organization, they should have significant experience with these arrangements. Higher risk level would most likely require practices to be part of a larger organization in some manner. Affiliation with a larger organization may promote oversight and education, but may also limit the number of practices that may participate.

3. What support would physicians and/or practices need from CMS to participate in a DPC model (e.g., technical assistance around health IT implementation, administrative workflow support)? 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? What types of support would practices need to effectively understand and utilize this data? How should CMS consider and/or address the initial upfront investment that physicians and practices bear when joining a new initiative?

A big concern for ACOs and other similar programs are around providing data, specifically the timing in which it needs to be shared and its usability. We think that both the support and data needs should be similar to those given to CPC+ practices. For example, CPC+ feedback reports provide not only directional information, but patient specific information for targeted care management. Learning collaboratives and resources are also advised. CMS should continue what they are already doing for those practices.

4. Which Medicaid State Plan and other Medicaid authorities do States require to implement DPC arrangements in their Medicaid programs? What supports or technical assistance would States need from CMS to establish DPC arrangements in Medicaid?

AGS is not commenting on this question.

5. CMS is also interested in understanding the experience of physicians and practices that are currently entirely dedicated to direct primary care and/or DPC-type arrangements. For purposes of this question, direct primary care arrangements may include those arrangements where physicians or practices contract directly with patients for primary care services, arrangements where practices contract with a payer for a fixed primary care payment, or other arrangements. Please share information about: how your practice defines direct primary care; whether your practice ever participated in Medicare; whether your practice ever participated in any fee-for-service payment arrangements with third party payers; how you made the transition to solely direct contracting arrangements (if applicable); and key lessons learned in moving away from fee-for-service entirely (if applicable).

AGS is not a medical practice and its comment is limited to the following: existing practice that contract directly with patients (e.g., concierge practices, opting out of Medicare) are extremely unlikely to be interested in the DPC model and we would suggest that CMS focus its DPC model on practices that participate in Medicare.

Questions Related to Beneficiary Participation

6. Medicare FFS beneficiaries have freedom of choice of any Medicare provider or supplier, including under all current Innovation Center models. Given this, should there be limits under a DPC model on when a beneficiary can enroll or disenroll with a practice for the purposes of the model (while still retaining freedom of choice of provider or supplier even while enrolled in the DPC practice), or how frequently beneficiaries can change practices for the purposes of adjusting PBPM payments under the DPC model? If the practice is accountable for all or a portion of the total cost of care for a beneficiary, should there be a minimum enrollment period for a beneficiary? Under what circumstances, if any, should a provider or supplier be able to refuse to enroll or choose to disenroll a beneficiary?

We support beneficiary choice and strongly encourage efforts by CMS to clearly define the mutual expectations and responsibilities of the patient and the physician. Education for beneficiaries should be simple enough so the patient understands what their participation means and what about their care will change (e.g. this is not managed care) and this education should not just be the responsibility of the enrolled practice. We support a voluntary explicit agreement between the doctor and the patient that lays out what services the practice can provide and encourages the patient to utilize those services. There should be no requirements for referrals or prior authorization except as they apply to all Medicare beneficiaries. Beneficiaries should not be allowed to enroll or disenroll with a practice more frequently than annually, with obvious exceptions for practice or beneficiary changes (such as moving). Allowing any change more frequently would make it administratively burdensome to attribute care and cost appropriately or to calculate PMPM payments accurately. Furthermore, it undermines incentives to invest in care management.

Therefore, we recommend a minimum enrollment period of at least one year but encourage CMS to do an analysis to see if a different minimum enrollment period would be advisable. With respect to attribution, CPC+ uses an attribution methodology that seems reasonable and could be used for a DPC model.

We also strongly urge CMS to develop a plan to encourage beneficiaries to explicitly designate a primary care provider (PCP). We need to move away from using claims data to identify PCPs. Satisfactory attribution of primary care accountability will not occur in any of the CMS programs without PCP designation and CMS will never get truly meaningful measures of performance without this kind of change. We recommend that CMS educate its beneficiaries that having a regular source of primary care is an important part of care, and that for most people high-quality health care starts with having a relationship with a trusted PCP. Primary care is a key feature of all high-performing healthcare systems.

We also encourage CMS to move to use of the patient relationship categories and codes to help define the mutual expectations of physicians and patients and to determine whether the patient relationship categories can be used for purposes of attribution.

7. What support do practices need to conduct outreach to their patients and enroll them under a DPC model? How much time would practices need to "ramp up" and how can CMS best facilitate the process? How should beneficiaries be incentivized to enroll? Is active enrollment sufficient to ensure beneficiary engagement? Should beneficiaries who have chosen to enroll in a practice under a DPC model be required to enter into an agreement with their DPC-participating health care provider, and, if so, would this provide a useful or sufficient mechanism for active beneficiary engagement, or should DPC providers be permitted to use additional beneficiary engagement incentives (e.g., nominal cash incentives, gift cards)? What other tools would be helpful for beneficiaries to become more engaged and active consumers of health care services together with their family members and caregivers (e.g., tools to access to their health information, mechanisms to provide feedback on patient experience)?

CMS will need to develop educational materials for physicians to share with their patients regarding enrollment in a DPC model. Physicians should not be held responsible for developing this material.

We think gift cards and other incentives for active beneficiary engagement is an interesting concept that CMS should explore. However, the burden should not be on the practice or physician to figure out and any gifts should be paid for by and come from CMS. In other words, we agree that CMS should facilitate practice ramp-up and beneficiary enrollment but should not place the burden on the physician practice – this is a CMS model and if CMS wants the model to succeed it needs to perform these activities and develop materials for physicians to give to beneficiaries. We also believe that CMS should consider incentives that promote voluntary enrollment in programs that include a PCP designation. These incentives should be designed so that beneficiaries receive them only if they truly accept a primary care relationship.

8. 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. Given the existing structure of Medicare FFS, are these types of incentives necessary to test a DPC initiative? If so, how would they interact with Medicare supplemental (Medigap) or other supplemental coverage? Are there any other payment considerations or arrangements CMS should take into account?

This is an opportunity, as with CPC+, to build in appropriate compensation for primary care. Waiving coinsurance and deductibles is an interesting idea but it must make sense as it is part of the entire payment structure and it is not possible to make a blanket statement about this until the rest of the payment structure is understood. Any proposed changes should be reviewed for the impact on standard

operations of practices that are providing care for many types of patients: commercially insured, Medicaid, Medicare Advantage, traditional Medicare, Medicare DPC enrollees, etc.

Questions Related to Payment

9. To ensure a consistent and predictable cash flow mechanism to practices, CMS is considering paying a PBPM payment to practices participating in a potential DPC model test. Which currently covered Medicare services, supplies, tests or procedures should be included in the monthly PBPM payment? (CMS would appreciate specific Current Procedural Terminology (CPT®1)/Healthcare Common Procedure Coding System (HCPCS) codes as examples, as well as ICD-10-CM diagnosis codes and/or ICD-10-PCS procedure codes, if applicable.) Should items and services furnished by providers and suppliers other than the DPC-participating practice be included? 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?

With respect to risk adjustment, AGS believe that using the HCC risk model makes them most sense as it is well understood and used by CMS for Part C. We also recommend risk adjusting for patients who are dual eligible beneficiaries and for beneficiaries with a confirmed diagnosis of dementia. This is in addition to using HCC. These patients require greater levels of support at the practice level.

AGS is uncertain how geographic adjustments would work and would be happy to work with CMS to identify appropriate geographic risk factors.

The most important consideration of any PBPM payment for primary care services is that it reflect the true costs of providing advanced primary care. This includes care management and support for the effective use of teams and inter-visit services. Specific CPT/HCPCS codes would depend upon the model and the general model and goals need to be articulated before such implementation detail can be provided. PBPM payments are best for services that are made over populations and would be cumbersome to report individually. They may also be used to bundle payment for services that are potentially over-used. Service specific payments may be provided as incentives to perform under-used services. With that in mind we believe that the monthly PBPM payments would reasonably include all office E/M services (for a DPC office based practice), including the welcome to Medicare physical and the annual wellness visits. CMS could consider including additional services that are frequently performed on the same date as an office visit (e.g., point of care lab tests and EKGs) but should only include those services that are performed frequently enough (e.g. 30% of the time) to increase the PBPM payment to appropriately reflect their inclusion. Such services should also be consistently predictable over a population so that a monthly payment is equitable. It makes no sense to include a particular service in the PBPM if the PBPM is not adjusted upwards to take the cost of performing that service into account.

Lastly, we note that in other sites of service, risk adjusted payments create an incentive to "up-code" using the ICD-10-CM coding system and CMS needs to take this into account. Paying primary care clinicians by risk-adjusted capitation will create a strong incentive for aggressive ICD-10 coding to boost the capitation payment. Such a system would require clear coding guidelines to define appropriate coding and minimize the influence of variations in coding intensity not related to actual disease burden. This is an ongoing problem in Medicare Advantage, and may be of even greater concern here, since the impact of coding on payment to the provider is more direct.

10. How could CMS structure the PBPM payment such that practices of varying sizes would be able to participate? What, if any, financial safeguards or protections should be offered to practices in cases where DPC-enrolled beneficiaries use a greater than anticipated intensity or volume of services either furnished by the practice itself or furnished by other health care providers?

PBPM payment for practices of varying sizes can be managed by restricting the degree of direct financial risk. We believe that the best measure of cost performance of a primary care physician or practice is the total cost of care. That said, it would be completely irrational to put most practices (except a very large one) at actual financial risk of the total costs of care (i.e., requiring the practice to refund to Medicare part or all of overages to predicted cost). Similarly, primary care practices should not be at direct risk for the cost of labs or MRI's etc. Primary care gets about 5 cents of every Medicare dollar, and these costs will immediately overwhelm practices. Instead a portion of what otherwise be received by the practice could be at risk (i.e., you don't get a bonus or a withhold from the capitation amount) if your risk adjusted costs are too high. Practices should also be protected against big outliers. For example, any patient with a total cost of care that is more than 3 standard deviations from the mean for that practice would not count against the practice in calculating bonuses, etc.

11. 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 services should be included and how should the level of risk be determined? What are the potential mechanisms for and amount of savings in total cost of care that practices anticipate in a DPC model? In addition, should a DPC model offer graduated levels of risk for smaller or newer practices?

We do not find taking on risk to be viable unless practices have minimum enrollment requirements and risk levels are based upon primary care revenue. Total cost of care can be used as a metric but cannot put practices at risk for dollar for dollar spending. Graduated levels may be a more viable option. At least 5,000 Medicare beneficiaries are needed in order to take this kind of risk and experience in MSSP suggests 25,000 may be better. See this current article in Health Affairs. (https://www.healthaffairs.org/do/10.1377/hblog20180507.812014/full/)

12. What additional payment structures could be used that would benefit both physicians and beneficiaries?

Additional payment structures could be ones like CPC+ with mixed fee-for-service and capitation and care management fees. Payments must include recognition of the costs of advanced primary care.

Questions Related to General Model Design

13. As part of the Agency's guiding principles in considering new models, CMS is committed to reducing burdensome requirements. However, there are certain aspects of any model for which CMS may need practice and/or beneficiary data, including for purposes of calculating coinsurance/deductible amounts, obtaining encounter data and other information for risk adjustment, assessing quality performance, monitoring practices for compliance and program integrity, and conducting an independent evaluation. How can CMS best gather this necessary data while limiting burden to model participants? Are there specific data collection mechanisms, or existing tools that could be leveraged that would make this less burdensome to physicians, practices, and beneficiaries? How can CMS foster alignment between requirements for a DPC model and commercial payer arrangements to reduce burden for practices?

If there are no claims submitted (e.g., such as in a capitation model), it may not be possible to get the ICD-10 data needed to do risk adjustment. Therefore, some sort of annual or semi-annual data submission mechanism should be created – as long as it is not burdensome. For example, CMS could require submission of two claims a year (e.g., January and July) to provide the data it needs to implement the model. Alternatively, CMS could initially continue to use clams submittal as the primary data collection, but should not require submittal of care management codes. We believe submission of quality measures may be able to be simplified, but the need for change may be dependent on program expectations. For example, if use of a certified EMR with eCQM is a minimum requirement, more simplified quality reporting suggestions are not needed. In any case, before selecting a mechanism for data submission, CMS should publish potential data submission options and ask for comment from stakeholders.

14. Should quality performance of DPC-participating practices be determined and benchmarked in a different way under a potential DPC model than it has been in ACO initiatives, the CPC+ Model, or other current CMS initiatives? How should performance on quality be factored into payment and/or determinations of performance-based incentives for total cost of care? What specific quality measures should be used or included?

Performance on quality should be benchmarked and factored into payment. CMS should use performance metrics with which physicians are familiar such as PQRS or MIPS measures and should make the reporting requirement as simple as possible. AGS is working to advance better quality measures. We also believe that quality reporting at the individual clinician level is unreliable. When it is used there should be success thresholds and not relative ranking payment methodology where losers fund winners. We also believe performance improvement should be recognized.

15. What other DPC models should CMS consider? Are there other direct contracting arrangements in the commercial sector and/or with Medicare Advantage plans that CMS should consider testing in FFS Medicare and/or Medicaid? Are there particular considerations for Medicaid, or for dually eligible beneficiaries, that CMS should factor in to designing incentives for beneficiaries and health care providers, eligibility requirements, and/or payment structure? Are there ways in which CMS could restructure and/or modify any current initiatives to meet the objectives of a DPC model?

AGS is not commenting on this question.

Questions Related to Program Integrity and Beneficiary Protections

16. CMS wants to ensure that beneficiaries receive necessary care of high quality in a DPC model and that stinting on needed care does not occur. What safeguards can be put in place to help ensure this? What monitoring methods can CMS employ to determine if beneficiaries are receiving the care that they need at the right time? What data or methods would be needed to support these efforts?

See answers to above questions. We believe that if practices submit claims and there are quality measures, beneficiaries should have the protections they need.

17. What safeguards can CMS use to ensure that beneficiaries are not unduly influenced to enroll with a particular DPC practice?

This is a matter for CMS to determine but CMS needs to tread lightly and make sure it does not interfere with the physician patient relationship.

18. CMS wants to ensure that all beneficiaries have an equal opportunity to enroll with a practice participating in a DPC model. How can CMS ensure that a DPC-participating practice does not engage in activities that would attract primarily healthy beneficiaries ("cherry picking") or discourage enrollment by beneficiaries that have complex medical needs or would otherwise be considered high risk ("lemon dropping")? What additional beneficiary protections may be needed under a DPC model?

This will be very difficult unless CMS requires an enrolled practice to enroll all its beneficiaries which would mean removing patient choice – this is something AGS disagrees with. Instead, if CMS believes a practice is cherry picking, it should confirm this is the case (e.g., is the enrolled population an outlier with respect to illness and comorbidities, as compared to other practices) and then educate the practice and if the practice doesn't enroll sicker patients, disenroll the practice from the demo. Practices should not be otherwise penalized for "cherry picking."

19. Giving valuable incentives to beneficiaries to influence their enrollment with a particular DPC practice would raise quality of care, program cost, and competition concerns. Providers and suppliers may try to offset the cost of the incentives by providing medically unnecessary services or by substituting cheaper or lower quality services. Also, the ability to use incentives may favor larger health

care providers with greater financial resources, putting smaller or rural providers at a competitive disadvantage. What safeguards should CMS put in place to ensure that any beneficiary incentives provided in a DPC model would not negatively impact quality of care, program costs, and competition?

CMS should be the only entity to provide "valuable incentives." Practices should not be allowed to do so.

20. How can CMS protect beneficiaries from potential risks, such as identity theft, that could arise in association with a potential DPC model?

AGS is not commenting on this question. We are not aware that the issue is specific to the proposed program.

Questions Related to Existing ACO Initiatives

21. For stakeholders that have experience working with CMS as a participant in one of our ACO initiatives, how can we strengthen such initiatives to potentially attract more physician practices and/or enable a greater proportion of practices to accept two-sided financial risk? What additional waivers would be necessary (e.g., to facilitate more coordinated care in the right setting for a given patient or as a means of providing regulatory relief necessary for purposes of testing the model)? Are there refinements and/or additional provisions that CMS should consider adding to existing initiatives to address some of the goals of DPC, as described above?

Currently acceptance of down-side risk is voluntary. Only organizations that are highly confident that they can avoid a penalty will accept. Therefore, the observation that the most successful ACO's are those that accept downside risk does not mean that if only everyone would accept downside risk, they would be more successful. This is the confusion of cause and effect.

1. If you want organizations to accept downside risk, there needs to be a fair opportunity and a level playing field.
    a. Abandon the use of historical benchmarks, which discriminates against higher performing organizations. No organization will accept downside risk and potentially endure financial losses while it watches its less efficient competitor across town avoid a penalty or even get a bonus.
    b. Abandon the use of national Medicare growth rate as the trending factor to determine spending targets. That approach leads to the possibility of large bonus or penalties that are entirely unrelated to performance, because of the variability of regional cost growth compared to national growth (which is an <u>average</u> of high and low growth regions). Move to regional growth as the trend factor. These changes make the financial model more similar to Medicare Advantage.

22. Different types of ACOs (e.g., hospital-led versus physician-led) may face different challenges and have shown different levels of success in ACO initiatives to date. Would a DPC model help address

certain physician practice-specific needs or would physician practices prefer refinements to existing ACO initiatives to better accommodate physician led ACOs?

AGS is not commenting on this question.

In summary, AGS supports the concept of DPC because it appears to be similar to the concepts included in CPC+; that said, it is not clear how the proposed DPC model is a meaningful improvement on CPC+ and whether another option would be to simply expand CPC+. For example, the shift to 100% capitation in order to reduce costs and improve quality is an idea that has not yet been validated by health services research. Therefore, while AGS supports CMS developing new payment models, we have concerns over whether the proposed DPC offers any benefits not already built into CPC+ and we encourage CMS to be very careful about how it implements DPC as proposed. Specifically, CPC+, which incorporates modified FFS payments and partial capitation, appears to be more consistent with improving care and reducing costs than the proposed DPC, because there is less of an incentive to refer patients out of the practice, and to not enroll, or dump, complex costly patients who require a lot of care, etc. This is because a reduced FFS payment for an office visit can cover the practice expense of the visit, so performing the visit does not generate out of pocket financial losses for the physician. That is not the case in all 100% capitation models and CMS needs to carefully consider this as it moves forward.

Thank you for the opportunity to submit these comments. We would be pleased to answer any questions you may have. Please contact Alanna Goldstein, agoldstein@americangeriatrics.org.

Sincerely,

Nancy E. Lundebjerg, MPA
Chief Executive Officer