AMERICA'S PHYSICIAN GROUPS
Taking Responsibility for America's Health

May 24, 2018

Mr. Adam Boehler
Deputy Administrator for Innovation and Quality
Director, Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via email at DPC@cms.hhs.gov

Dear Deputy Administrator Boehler:

We, America's Physician Groups (APG), write in response to the Request for Information (RFI) on Direct Provider Contracting (DPC) models. APG welcomes the opportunity to provide feedback based on our members' expertise and success in innovative payment models. This RFI underscores your commitment to transforming our nation's healthcare delivery system from volume to value, something APG and our members wholeheartedly support.

We strongly support the Direct Provider Contracting (DPC) proposal described below, which we refer to as the "Third Option". It has been approved and adopted by our APG Board of directors and mimics the integrated, capitated payment and delivery model used by APG members across the country in virtually all other programs and products.

The Third Option is a bold and sweeping proposal that would bring risk-based integrated and capitated care to Original Medicare, and it should be tested by CMMI. This model would create a new and additional Advanced APM which providers and beneficiaries in Medicare need to continue the evolution of value-based care.

APG represents over 300 physician organizations across 44 states, Washington, D.C., and Puerto Rico. Our members participate in pay-for-performance programs across all payer types, including the Medicare Shared Savings Programs (MSSP), CPC plus, the Next Generation Accountable Care Organization (ACO) program, and accept capitated payments from both Medicare Advantage (MA) and commercial plans. Moreover, many APG members have successfully operated under full risk-based models for over two decades and have developed the necessary infrastructure and expertise to be successful in innovative risk bearing models across a wide variety of socioeconomic and geographic areas.

APG members are truly taking responsibility for America's health by holding themselves accountable for patient outcomes by providing the patients and communities they serve with access to the best possible healthcare. Our preferred model of capitated, coordinated care avoids incentives for high utilization associated with fee-for-service (FFS) reimbursement. Instead, we believe that this model aligns incentives for physicians to provide the best care in the right

setting to improve the health of entire populations, particularly chronically ill individuals. These capitated payment arrangements create incentives for (1) a team-based approach that emphasizes primary care and disease prevention; (2) greater access to new and innovative medical technologies and treatments and, most importantly; (3) the achievement of better outcomes in both cost and quality of care.

Executive Summary of APG Response

Attached hereto as Appendix A is a copy of our Third Option. It has attracted considerable support among health care policy leaders including Members of Congress. Set forth below is a summary of its salient features:

- It features prospective population payments to physician organizations that include robust quality measurements with active beneficiary engagement.

- It would allow the Centers for Medicare & Medicaid Services (CMS) to directly contract with clinically integrated organizations (CIOs). CIOs may be existing physician organizations or newly formed entities. The CIO would be explicitly physician group centric, however, other providers could take ownership stakes, or could accept a measure of risk and accountability through affiliation agreements.

- To participate in this model, CIOs would have to meet current CMS and State requirements, similar to those required for existing Medicare Accountable Care Organization (ACO) participants such as a formal legal structure that allows the organization to receive capitated payment and pay contracted or employed providers.

- The model provides for the active enrollment by beneficiaries – a design element critical to the goal of achieving the full beneficiary engagement.

- CMS would establish capitation rates including the standard Medicare Part A and Part B benefits, using methods and benchmarks similar to those used to establish rates for Medicare Advantage (MA) plans. The payments would be actuarially sound, risk adjusted, and updated annually. CMS would pre-pay this amount to the CIO each month in lieu of Medicare Part A and Part B FFS payments for enrolled beneficiaries, and the CIO would then be responsible for the payment for all professional and hospital services, whether provided in-network or out-of-network.

- Beneficiaries would be encouraged to stay in network by differential copayments and co-insurance, paying higher copayments for going out of the CIOs contracted or employed network, and lower or no copayments for services received in-network. Medicare supplement benefits would only be payable for services in network.

- Robust publicly reported quality and efficiency measures would be used similar to the MA Stars rating and could be used to make comparisons between the CIOs and FFS.

- CMS would contract with one or more Affiliated Service Organizations (ASOs) to provide a full range of necessary administrative services, including quality and data reporting, payment, financial and patient cost sharing tracking, enrollment, and all other back office functions. These ASOs would serve as fiscal and administrative intermediaries similar to those currently engaged by CMS and by self-insured employers.

APG's response to specific questions in the RFI are as follows:

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?***

   Under the Third Option, CMS would contract directly with clinically integrated organizations (CIOs). CIOs may be existing physician organizations or newly formed entities. It is indeed feasible and desirable for small and independent practices to participate in a DPC model, including our Third Option. Small and independent practices may contract with the CIOs under the Third Option. Those CIOs are very similar to the ACOs in the MSSP program, and very similar to IPA organizations across the country. Physicians can thus retain their independence, and also participate in CIOs by way of contract, thus accessing the centralized support and infrastructure that the CIO will furnish.

   The CIO would be explicitly physician group centric. However, other providers could take ownership stakes, or could accept a measure of risk and accountability through affiliation agreements. This could include a broad spectrum of health care providers, including physicians, hospitals, nursing homes, home health organizations, and other entities wishing to be accountable for the delivery of care to a defined patient population across the continuum of care.

To participate in this model, CIOs would have to meet certain requirements, similar to those required for existing Medicare ACO participants:

- A formal legal structure that allows the organization to receive capitated payment and pay contracted or employed providers;
- Primary care professionals sufficient to care for the defined population;
- A minimum of 10,000 participating beneficiaries;
- Systems in place to identify and provide care for high risk and complex patients;
- The ability to stratify the population (identifying patients with multiple complex chronic conditions and to tailor care management programs to the patient population);
- Demonstrated experience in quality performance programs.

It is essential that all physicians have access to the tools, education, and practical experience necessary to move from FFS reimbursement towards APMs that reward and incent physicians for improved patient outcomes. Central to the success of this movement is flexibility and varying degrees of acceleration. A significant "on-ramp" is necessary for physicians to gain the skills they need to be successful. Simultaneously, groups of physicians who have demonstrated success in upside only or partial risk-bearing arrangements should have access to increasing levels of risk up to full capitation for total cost of care.

APG recognizes that solo and rural physicians often have the most difficulty participating in advanced APMs. CMS should thus better utilize emerging technology and should also explore new ways to allow providers to group together, regardless of their Tax ID number (TIN), ownership interest, or even geographic location should be a critical component of any forthcoming model. This has already begun with the introduction of Virtual Groups in MACRA.

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.

Participating physicians must be able to demonstrate a level of experience and sophistication in order to be eligible to participate in higher risk-sharing models such as DPC. The same requirements for CPC plus (as outlined below) represent an acceptable framework:

- Access and continuity (e.g. Same day access, 24/7 telemedicine access and e-consults)
- Proactive care management
- Comprehensive coordination with specialists and hospitals
- Patient and family engagement
- Integrated care team approach

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?***

CMS should provide the financial feedback reports in a method to the DPC practices that are formatted in a way that is clear and easy manipulate (e.g. an interoperable dashboard) and at physicians' current level of health IT sophistication. With the advent of the CMS blue button, real time information should be more readily available to both CMS and physicians. Additionally, smaller practices may need further technical assistance in administering a different billing system from FFS and should be provided this education from CMS. Perhaps additionally funds to the TCPI (Transforming Clinical Practice Initiative) may provide this specialized learning technical assistance.

Further, there is a role for a broad range of third-party organizations to assist in providing services, integrating and/or coordinating the work of practicing physicians and other

clinicians. CMS should encourage and permit these organizations to serve as a convener for interested physician participants

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?***

   Currently, many States are already facilitating discussions with managed care organizations (MCOs) to modify their plans to allow the development of risk-based contracts with providers. CMS should provide guidance to States with a core framework that these plans must adhere to in order to ultimately gain approval from CMS and the Office of Management and Budget (OMB). For example, this guidance could come in the form of a series of educational webinars or open tele-office hours. This guidance should include specific metrics to all contracts in order to qualify for advanced APM status.

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).***

   APG strongly cautions against the implementation of a concierge-type model that would include "balance billing". These models have typically only been successful with small panels, low risk, and a narrow scope which limits the opportunity to achieve the necessary improvement in population health outcomes needed to change the trajectory of the nation's health care costs. Further, this type of concierge model often leads to fragmentation of care. The patient panels also tend to be quite small in these types of models which make risk sharing increasingly difficult. Without a sufficiently large patient panel, practices are unable to adequately account for statistical variation.

   If CMS narrows the scope of any forthcoming DPC model to accommodate this, the potential to impact social determinants of health (SDOH), which determines 80 percent of care outcomes, will be extremely limited. We also are concerned that these models will not be able to adequately address the needs of seniors with multiple chronic

comorbidities that require the coordinated services of both primary care physicians and specialists. We know that chronic care accounts for over 90 percent of Medicare spend, and all new models must be well designed to address that disease burden. We also have concerns that seniors will not have the funds, or the desire, to "self-pay" for primary care services, especially those already provided at no additional cost in MA or covered by Medicare supplemental benefits.

Addressing SDOH must be a critical component of a DPC model. We are already starting to see exciting new tools for providers in the new MA plan rules to address SDOH, and beneficiaries in traditional Medicare deserve the same access to these critical services and supports. To limit them in order to accommodate only a small number of providers is a step backwards for the nation's healthcare delivery system.

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?***

Beneficiaries who enroll would commit to receiving services in the CIO for one year. Experience has taught us that active, intentional enrollment by an engaged and informed beneficiary is vastly superior to passive attribution models used in traditional Medicare ACOs.

Our model includes differential cost sharing that would induce beneficiaries to remain in-network. Beneficiaries wish to visit physicians not contracted with the CIO would be able to do so, but they would pay higher co-payments and co-insurance for the privilege. It would thus operate in a manner similar to existing and proven point-of-service models seen in commercial insurance.

To facilitate beneficiary election of a CIO, quality and service information would be made available to the beneficiary. CIO-level information would be developed by stakeholders, including physicians, approved by CMS, and then disseminated by both CMS and the CIO to allow consumers to make fully informed choices about their care.

Beneficiaries would be empowered with information regarding the quality, cost, and scope of services available under each of FFS, MA, and the CIO, including additional care management programs or benefits. For example, CMS could develop a patient-facing dashboard (or an app) that would contain quality metrics, similar to the Quality Measures and Performance Standards in the ACO program reported at the CIO level. Patients could then compare the performance of their selected CIO directly.

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)?***

   It is absolutely critical that beneficiaries have access to the information and education they need to make informed healthcare choices. CMS must ensure that DPC enrollees clearly understand the model and what services are included under it. As this model relies on patent engagement to be successful, an informed and committed patient panel is essential.

   Further, CMS should directly contract with an Affiliated Service Organization (ASO) to provide the infrastructure of the enrollment process itself. This is similar to the self - insured employer model. The practice could send the ASO the list of their Medicare FFS beneficiaries that qualify for the model and the ASO could: provide the beneficiary education, assist in the completion of the application, and facilitate any handling questions related to Medicare benefits.

   We do not support direct gift incentives like cash cards since they are difficult to track and have not been proven to be particularly effective. However, waiving costs for services already in use (e.g. gym memberships, nutrition services, and certain counseling services) would be a desirable benefit.

   Rather than building expensive health plan infrastructure and capacity, CMS would, at its expense, contract with one or more ASOs to administer the eligibility and enrollment

process, make capitated payments, receive encounter data from the CIOs, operate the quality and incentive bonus program, and conduct all other necessary functions.

In particular, the ASO will be necessary to handle the complexities associated with administering differential cost sharing for the out-of-network benefit. CMS may elect to contract with one or more national insurance carriers with the existing infrastructure and systems necessary to rapidly implement this program. The expectation is that the use of national health plans in this ASO, non-risk bearing capacity will result in lower cost for these services than currently experienced within MA. The ASO model will mimic the use of an ASO by self-insured employers in the commercial context.

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?***

   Again, beneficiaries must be free to access services from any Medicare contracted physician. However, to incentivize beneficiaries to access in-network care as directed by their chosen primary care physician, services rendered by out of network providers would be subject to higher out of pocket costs. Prior authorization for certain high-cost services would be required. The higher cost-sharing for use of services outside the CIO is designed to achieve the twin goals of allowing freedom of choice but incentivizing the efficiencies and higher quality that can be obtained by consistently accessing a highly organized, financially aligned, and electronically connected network of team-based providers. To encourage beneficiaries to seek high-value care, including preventive services, beneficiaries would not need to pay a deductible and would have no copayments for preventive services.

<u>Questions Related to Payment</u>

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?

The model should cover all standard Medicare Part A and Part B benefits.[1] CIOs would have the option to work with a Medicare drug plan to offer Part D benefits, but CIOs would not be required to offer pharmacy benefits. If the CIO did not offer Part D benefits, such benefits would continue to exist alongside the model.

The Part B premium would be reduced for beneficiaries that select to participate in the model for one year and actively select a primary care physician within the CIO. The percentage to be waived is to be determined with the aim of providing sufficient incentive for beneficiaries to select the CIO and providing sufficient funding for the program. This partial waiver of premium, coupled with the provisions relating to Medicare supplemental insurance below, should make the model attractive to many seniors.

Accurate risk adjustment is critical to the success of this model. Importantly, risk score growth should not be capped and should be allowed to vary with patient enrollment.

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?

CIOs should be obliged to have a patient panel of greater than 10,000 to help spread the risk and cost over the population. Additionally, CIOs may be required to purchase "stop loss" coverage to indemnify them for particularly high-cost patients. The PBPM payment should be prospective and encompass total cost of care including both primary and specialty services. It is critical that this DPC model achieve the goal of expanded access to advanced APMs for both physicians and patients, and as such it must at least meet the nominal risk threshold.

[1] A variation, or track, within the model could also include a capitated payment for professional services only (Part B). This is a common arrangement used in the marketplace today and could serve as a pathway to engage additional physician groups and organizations in value-based care.

CMS would establish capitation rates including the standard Medicare Part A and Part B benefits[2] using the same method it sets for rates for MA plans. The payment should be actuarially sound and would use accurate risk adjustment with a prospective update each year. CMS would pre-pay this amount to the CIO each month in lieu of Medicare Part A and Part B FFS payments and the CIO would then be responsible for the payment of all professional and hospital services, whether provided in-network or out-of-network.

It is important that practices of varying size and geographic location be afforded flexibility in risk adjustment. For example, certain practices are disadvantaged because they operate in a high-labor, high-efficiency area which necessitates a special adjustment to the risk calculation. CMS should explore alternative methodologies to address this issue. The Next Generation ACO program has had some success addressing this issue; the model should draw from that program's experience and improve upon it.

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?***

The capitated of PBPM payment we propose would effectively make CIOs at risk for the total cost of care (excluding Pharmacy) for all Part A and B services.

Allowing practices to have access to greater amounts of risk is paramount to advancing the value movement. As previously stated, there should be an on-ramp to allow physicians and practices to gain necessary practical experience and skills to succeed in higher risk models. The Third Option Model would allow for both global and professional-only levels of risk.

Importantly, all payments – PBPM and Performance Based Payment (PBP) – should be risk adjusted using the CMS-HCC model that is currently utilized in the MA program. Developing any variation from the MA program generates confusion among participants. Additionally, SDOH (Social Determinants of Health) metric other than a percent of the "dual" population should be included. Any methodology developed for both the PBPM and PBP should be fully transparent to enable the practices to model any changes in the variables. The "black box" approach of other models have led to awardees unpleasant

surprises at performance years end. Ideally, CMS quarterly projections should not be off by more than 10 percent at years end.

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

CMS should deploy a quality measurement program modeled after the MA Stars program. Bonuses should be based on performance and should be paid directly to the CIO. Additionally, CMS should consider additional innovative payment structures to encourage collaboration with community-based organizations, social service and public health agencies and other third-parties to better address SDOH and supplemental benefits essential to improving population health.

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?

ASOs would collect, process, and report data and results to both the CIO and CMS in a manner similar to that done by MA plans and ASOs in self-insured employer models.

As technology and informatics advance, so too must the practice of medicine to keep pace. Patient data is a critical component of any population health model. Accurate, reliable, timely, and clinically relevant data not only allows physicians to better care for patients and entire populations, it also allows patients to better understand their unique health needs and challenges and better participate in their care plans. Access to this data allows for a better understanding of quality and resource-use management – an essential part of controlling rising healthcare costs and improving patient outcomes.

CMS should consider leveraging third-party collection methods such as clinical data and disease registries. Recognition of third parties, registries, and digital platforms powered

by modern data analytics already in use in the commercial and private sector can vastly improve and augment current CMS data system capabilities.

Importantly, this data should also be disseminated to patients. This will achieve the goal of increased transparency and better patient access to their own healthcare information.

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?***

Two layers of quality and efficiency reporting and performance evaluation should be used. One would be an external, MA Stars rating or ACO-like quality reporting system. These measures would be publicly reported, would assess quality, efficiency, and patient satisfaction at the organization level, and would be used to make comparisons with MA and FFS Medicare. Quality measures would be developed, tested, and rolled out consistent with accepted practices. These measures would apply and be reported at the CIO level (not the individual provider level).

In addition, to ensure that CIOs have a strong business case for the delivery of high quality care, CIOs would be required to maintain a pay-for-excellence program to incent their downstream providers to deliver high quality care. The compensation payable to providers under these programs would be paid by the CIO from the capitation rates (CMS would not make a separate payment to the CIO's individual providers). Under this program, incentive compensation of as much as 15 percent of total provider compensation will be tied to high performance on quality measures, a model which has been demonstrated to successfully drive provider behavior.

CMS would develop quality floors for CIO participants. If the organization's performance fell below the floors, the organization would no longer be able to participate as a CIO. In the years following the MACRA advanced APM bonus years, CIOs should be eligible for an incentive program like the MA Five Star incentive program, where high performers are eligible for additional payments.

<u>Questions Related to Program Integrity and Beneficiary Protections</u>

15. 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?

The use of a quality and performance measure program, such as the in the MA Stars program, will prevent any stinting on services and will create further incentives for the delivery of high quality care, both for individual beneficiaries and to the enrolled population. CMS should take steps to improve quality transparency including metrics on prior authorization denials and wait times. Further, the Agency should take steps to implement a public-facing patient feedback dashboard that is interoperable with CMS Blue Button and 1-800-Medicare. CMS must include quality metrics in its DPC contractual requirements that primarily focus on outcomes measures and include patient-reported satisfaction metrics.

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

CMS should issue guidance with all DPC contracts that explicitly outlines permissible marketing and communication standards. Further, CMS should increase investment and training for State Health Insurance Assistance Program (SHIP) staff to ensure they are able to assist beneficiaries navigate the varies options available to them under the Medicare program.

17. 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?

Adequate risk adjustment is critical to disincentivize organizations from engaging in cherry picking or lemon dropping beneficiaries. A percent of the "duals" population is not a sufficient way of properly adjusting patient panels. DPC providers should be rewarded for taking on the most vulnerable and chronically ill patients, not penalized. CMS should also conduct regular audits and review the claims history of DPC beneficiaries. Practices should not be allowed to engage in targeted marketing to existing patients based on health status.

Questions Related to Existing ACO Initiatives

18. 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?

Further actions must be taken by CMS to encourage the participation in and proliferation of two-sided risk arrangements across the Medicare program. These two-sided risk arrangements shift accountability from healthcare payers and move more to providers. This helps align incentives for providers to engage more with patients to determine the best possible course of care and also improves healthcare utilization decisions.

Improvements can and should be made in existing initiatives including the Medicare ACO program and Comprehensive Primary Care Plus (CPC+) models, including allowing these providers to move into increasing levels of risk more easily. For example, these providers should be able to easily move to a DPC model without penalty. Our members have indicated a great deal of satisfaction with CPC plus and consider our Third Option model the next iteration of these programs. The Third Option, as stated, provides for direct contracts between CMS and physician organizations for services for beneficiaries in Original Medicare.

19. 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?

The DPC model we describe above effectively eliminates design shortcomings inherent in ACOs – CIOs would be capitated and thus create aligned incentives across all participating providers. ACOs are built on a fragmented FFS platform. Beneficiaries in CIOs would enroll and thus be actively engaged. Most beneficiaries in ACOs don't even know they belong to and ACO when attributed. Beneficiaries in CIOs would be incented to stay in-network where quality and cost savings can be managed and achieved. Beneficiaries in ACOs can obtain services anywhere, thus making the management of cost and quality almost impossible.

Rather than making "refinements" to a highly flawed ACO model, now is the time for the bold movements Secretary Azar has requested for the launch of models already proven to work well, lower total cost of care, and improve quality.

Conclusion

Both the empirical evidence and our members' experience are clear: direct capitated payments not only generate savings for both CMS and the provider, they also clearly yield better patient outcomes. The time for the next iteration of the ACO program has come. Physician organizations have long called on CMS to articulate the ultimate destination for delivery system reform. Our proposed Direct Provider contracting model – The Third Option - offers that destination and will be an attractive APM option for capable, risk-bearing organizations across the country.

Again, we applaud you for taking steps to proactively consult with the provider community as you work to draft and implement the Direct Provider Contracting model. If you have any further questions or would like additional detail please feel free to contact Valinda Rutledge, Vice President of Federal Affairs, at (202) 770-1863 or vrutledge@apg.org. We appreciate the opportunity to provide these comments and look forward to a successful launch!

Sincerely,

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DONALD H. CRANE

President and CEO